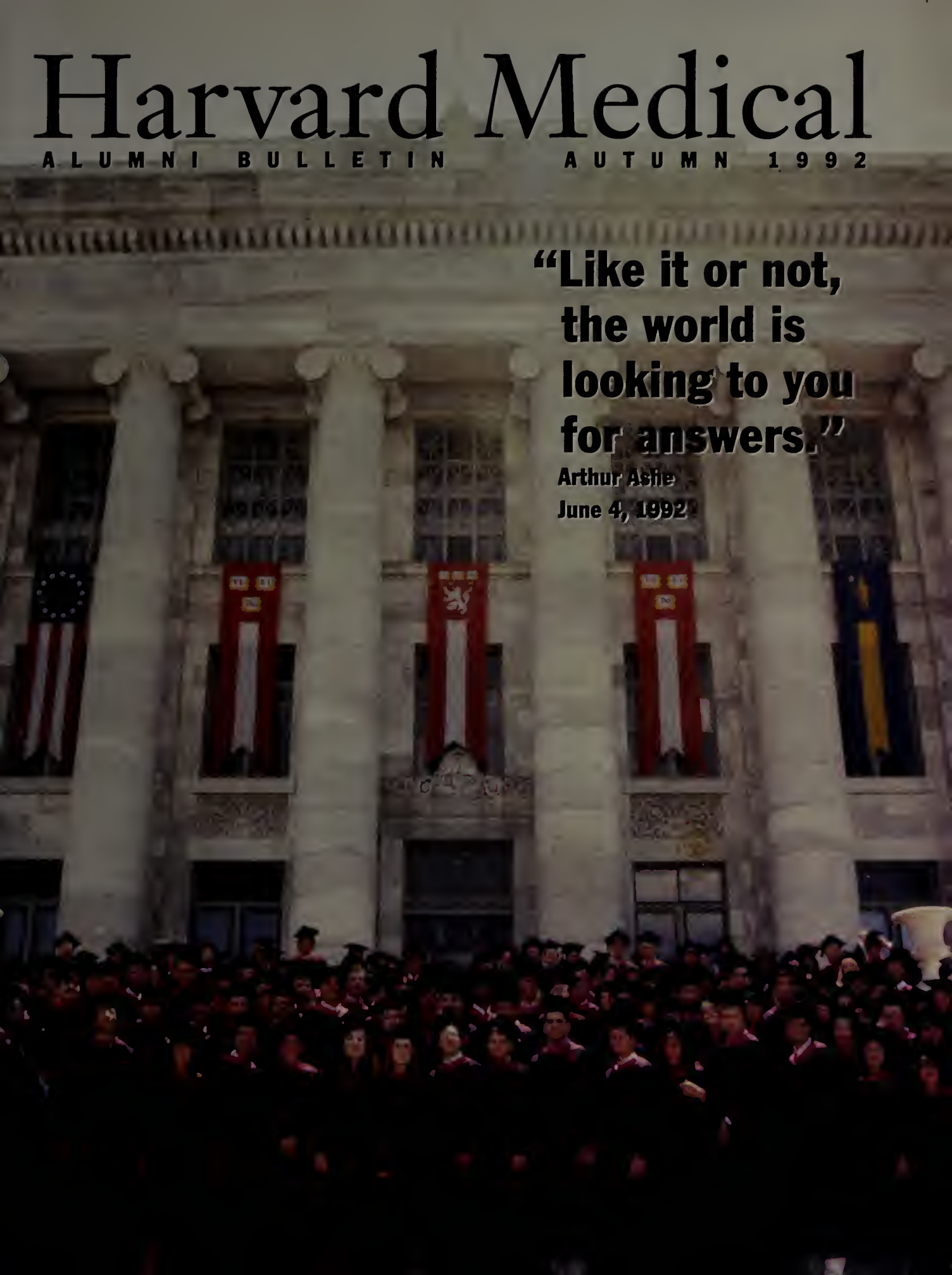
Harvard Medical

ALUMNI BULLETIN AUTUMN 1992



"Like it or not, the world is looking to you for answers."

Arthur Ashe

June 4, 1992

Fellowships for HMS Alumni

1992–1993

Fellowships are available for graduates of Harvard Medical School to undertake a year of post-graduate study. The amounts awarded for stipends are determined by the specific needs of the individual: $20,000 – $30,000 is the norm.

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The Committee on Fellowships gives preference to those Harvard Medical School graduates who:
1
Have already demonstrated their ability to make original contributions to knowledge.
2
Have planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.
3
Clearly plan to devote themselves to careers in academic medicine and the medical sciences.

The Committee requests that applications be submitted not more than one year in advance of the requested beginning date. The Committee meets once a year in January to review all applications on file by December 31. Applicants will be notified by February 15.

Information and application forms may be obtained from:

Committee on Alumni Fellowships
Harvard Medical School
Room 414, Building A
25 Shattuck Street
Boston, Massachusetts 02115
617/432-1596

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Cover photograph and Class Day photographs by Michael Maloney

Alumni Day photos by Vin Catania

Inside HMAB

In step with the precession of the solstices, Class Day and Alumni Day happened again the first week of June. The former was graced by a glorious spring afternoon; Alumni Day shivered through the kind of Northeaster special to New England. But beneath the big tent, an inner warmth pervaded.

This is an important year for the Alumni Association—its 101st. Carl Walter '32 has left us, and now Joe Murray '43B, after his extraordinarily graceful years as chairman of the Alumni Fund, has stepped down. What more fitting time for the Class of '67, under the leadership of Richard Shulman, class agent and president, to double the customary 25th-year gift—not in the spirit of competition but of affection for the school. And how nice for Doris Bennett '49, former president of the Alumni Association, who will chair the Alumni Fund.

In this issue you will find the Class Day addresses; notably that of Arthur Ashe who generously volunteered to bring his own special views to the graduating class. He was followed by Lewis First '80, long a favorite teacher among the undergraduates, and two members of the graduating class, Marc Laufgraben and Joe Rhatigan.

Alumni Day, under the articulate moderator-impresario Dan Federman '53, dean for medical education, was organized around the broad topic of the doctor/patient relationship. George Bascom led the way with an exceptionally moving poetic essay. Leslie Heafitz '65, followed with a patient's-eye view of cancer; Tom Gutheil '67 merrily represented the psychiatrist's view, and Elizabeth Howell '93 described the New Pathway side of the problem as the student sees it. The entire program was well spiced with many comments and questions from the audience as lots of people had their say.

J. Gordon Scannell '40

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Letters

Diagnosis Disputed

Purcell's elegant photographs of anatomic specimens from the University of Leiden published in the Summer 1992 issue of the *Bulletin* include a color photograph of two 19th century skeletons identified as displaying "the pathological anatomy of kypho-scoliosis." In fact, the skeleton on the right, aptly described as "gracefully bowing," appears to me to represent not kyphoscoliosis but Pott's disease. Note that the gibbus deformity is at the T-10 or T-11 levels, that there is no evident scoliosis, and that the shoulders appear to be in normal position. On the other hand, the seated skeleton on the left does appear to have kyphoscoliosis. Of course, all of this is a bit difficult, because the photograph gives us a view from only one point.

Tuberculosis has been with the human race since prehistoric times, and acid fast bacilli have been stained in rehydrated tissues from both Egyptian and Peruvian mummies. The characteristic spinal deformity of Pott's disease, well demonstrated in these mummies and so nicely represented in Purcell's photograph, is represented in prehistoric art with surprising frequency, and its presence in statuary may provide a clue to the epidemiology of prehistoric tuberculosis. The enormously high prevalence of tuberculosis in 19th century Europe is well known and its occurrence in notable personages of that era has been chronicled by several authors.

Currently, extrapulmonary tuberculosis represents 18.5 percent of reported cases in the United States, although vertebral tuberculosis accounts for less than 0.5 percent of reported tuberculosis. Data from developing countries are limited. Duraiswami states that Pott's disease accounts for 45 percent of skeletal tuberculosis in India. My own experience (anecdotal and not well documented) suggests that this form of chronic tuberculosis remains widely prevalent in populations where treatment of tuberculosis is often delayed or not readily available.

Thomas M. Daniel '55

The Haitian Tragedy

Thank you for printing Paul Farmer's gripping account of the tragedy that afflicts Haiti. For those who agree that the United States through its policies contributes to this tragedy, several organizations are working to build political awareness and a consensus to change these policies—one of them is called the Haiti Communications Project: 11 Inman St., Cambridge, MA 02138; (617) 868-2900.

Michael Potter '90

What Really Counts

I was sitting around here feeling sorry for myself the other day, thinking my profession had just lost all its luster, when I picked up the *Bulletin* and read George Bascom's great article on "Cowboys and Other Characters" (Spring 1992). It made my day and made me remember what really counts in this profession of ours, despite all the "medi" this and "medi" that, pay or no pay, English speaking or not. Thank you so much for putting into words what medicine and surgery should be—service to our fellow man.

W. Lane Verlenden '71

Horsing Around

Recently I received from a colleague a copy of the article by Paul Altrocchi '56 in the *Bulletin* (Spring 1992) in which he indicates that he is alive and well in Bend. He and I have had a long and special relationship through Andover, the NIH and Stanford, with his detour through Harvard while I was at Duke.

As he has noted, Bend is "remote from California's hectic pace" and to his liking. His observations confirm my own experiences following my move to the hinterland of the Carmel Bay. Hanging here on the edge of the continent and looking down the coast at the cliffs of Big Sur, I can understand Paul's appreciation of the "tranquil, unspoiled and truly lovely natural surroundings" of Bend.

His description of practice in Bend seems very similar to my own with regard to the unusual problems posed by rural accidents. I was interested in his patient described as a "ferrier." Paul noted that "despite training in Latin in pristine halls of East Coast educational institutions," he was not familiar with that term. Later, he described his patient as a "horseshoer." I was surprised to find that the "ferrier" is what in California we refer to as a "farrier." Our "ferriers" are boatmen while our "farriers" shoe horses. Occasionally I have heard redneck farriers use the term "ferrier" in describing the gay lifestyle in San Francisco with endearing terms such as "the ferrier the merrier."

It would be potentially dangerous, I think, for you to address these farriers as ferriers, or could it be that your anthropology major from Harvard prepared you to be a potato(e)-head in spelling?

William R. Lewis, MD

Doctors Shirking Duty

I have read from cover to cover the Spring 1992 issue of the *Bulletin*. Unfortunately, each issue records the demise of more friends, but since all of us are outliving the statistics for life expectancy, what do I expect?

I wrote to one of your authors, Dr. Weaver, because last evening on "60 Minutes" there was a segment on doctors who accept large amounts of money for training, then ignore the contract they have signed to practice

in deprived neighborhoods. I suspect the numbers are few, but it amazes me the government does not immediately take firm action. The facts seem obvious. To me the AMA should take action to encourage states to cancel one's license where such abuses occur. One state already has. But then I suppose the due process would kick in and the rascal would be ready for retirement before anything happened.

John Lowrey '40

More on the Halloween Incident

I recently received the Spring 1992 issue of the *Bulletin*. I really enjoyed its overall flavor and I found some of the pieces written by practicing alumni truly moving. But that is not what prompted me to write this letter. I am writing to you to express a deep unease with Harvard's response to the Halloween incident, described in Dean Tosteson's communication.

In sum, this event was based upon a disagreement between a black student and a white student about (unintentional) racial insensitivity at a medical student party, which led to a single punch being thrown. I think the school deserves credit for not evading the incident because of the aggressor's race. I think it is also praiseworthy that the school has protected the identity of those involved.

But if this were indeed a unique incident, without a prior history of insensitivity on the one hand, or recurrent violence on the other, then apologies, restitution, and a stern warning that this behavior was unacceptable would have been sufficient. For the provocateur/victim, sympathy as well as some advice should have been sufficient. (If civil or criminal charges were filed, then the courts would have had jurisdiction.)

This course would have received wide publicity through student grapevines, would have decreased the chances for charges being pressed, and could have been the basis for organized discussion among a multi-ethnic community such as HMS. It would have reflected the need for reconciliation and benevolence when dealing with the passion of youth. I cannot believe that it is Harvard's custom to suspend every student who has ever thrown a punch.

Instead the sequence of events became a parody of the academic approach to a politically charged issue. Not one, but two faculty committees were required to deal with this issue. Lawyers were (quite properly) engaged, expulsion considered, suspensions ordered and medical ethics were used as justification to consider whether this student should be denied a diploma. (It is not clear from Dr. Tosteson's statement whether any specific criteria for expulsion are circulated or discussed with students when they matriculate.)

What I find particularly egregious is the requirement for psychologic counseling. I offer my reasons. First, the use of psychiatry to quash unwelcome behavior smacks very strongly of the excesses of the former Soviet Union. Second—since you will probably reject the comparison with the USSR—is that coerced psychiatric counseling contaminates the psychiatrist/client relationship and prevents the uncensored flow of information from patient to doctor since the goal of the relationship is no longer the best interest of the patient, but rather a stipulated judgment that the patient is no longer a threat to others.

Third, and most philosophically, is that although the university has the right to expect students to adhere to certain standards of behavior, it does not have a right to define standards for thoughts. The insistence on compulsory psychiatric rectification of thought is a totalitarian idea, reminiscent of Big Brother. I speak with the perspective of experience at Stanford, where these Orwellian images flourish in the minds of the medical school administration, who used this same approach as a condition for the "rehabilitation" of one of our neurosurgeons in order to rescue him from his incorrect (sexist) attitudes.

With respect to the white students in blackface, they have learned a painful lesson and they have apologized. Why should they receive a punitive assignment, even if it has academic color? They were entitled to their choice of costumes and they bore the responsibility for their actions. In my opinion, Harvard has no claim to punish people for self-expression. (In fact, Harvard was ridiculed for doing so in a recent issue of *U.S. News and World Report*.)

I am sorry that HMS suffered a racial incident, but it was less serious than Los Angeles. I am sorry that a student received a laceration and a black eye. But these will heal. What I am most sorry about is that some old-fashioned common sense, combined with a spirit of reconciliation and community, was displaced by an academic pageant of committees, hearings, enforced psychiatry, etc., the sum of which is more depressing than the incident itself. I honestly thought Harvard could do better.

Mark G. Perlroth '60

Pulse

Photo by Barbara Steiner

Teaching awardees: Julian Seifter, Gillian Lieberman, Thomas Graboys and Diomedes Logothetis.

Top Teachers Awarded

Annually, faculty-student committees recognize outstanding teaching with teaching awards. This year, six faculty members were honored.

William Cochran '52, associate clinical professor of pediatrics, received the Robert S. Stone Award, which is given to an HMS faculty member on the staff of Beth Israel Hospital. Cochran was noted for his "engaging, enthusiastic teaching style, astute medical insights, and sensitivity to patients and parents."

Robert Schiffman, MD, clinical instructor in medicine, received the Leo A. Blacklow Teaching Award, given to a physician at the Mount Auburn Hospital who is an HMS faculty member. He was described as a tireless, outstanding role model. Said one student, "I would only hope to emulate his gentle manner, keen insight, and most of all, obvious dedication to his profession and patients."

Faculty Prizes for Excellence in Teaching were awarded to four faculty members involved in each of the four years of medical education. Diomedes Logothetis, MD, instructor in cellular and molecular physiology, was honored for his first-year curriculum, most notably for his multiple roles in the Metabolism and Function of Human Organ Systems course. One student remarked, "His passion for science is truly inspiring." Another said, "I had such a good experience that I stayed on a second year to help as a lab tutor."

Julian Seifter, MD, assistant professor of medicine and physiology, received the second-year teaching award for his work in the Metabolism and Function of Human Organ Systems course and in the renal pathophysiology section of the Human Systems course. A colleague remarked about Seifter, "I found his remarkable ability to lead students toward the answers to their own questions particularly impressive; it built students' confidence in their own knowledge and problem-solving skills."

The third-year teaching award was given to Gillian Lieberman, MD, instructor in radiology, who became director of the core clerkship in radiology in 1989. Especially popular with students, Lieberman has annually received high praise in the Student Evaluation Guide. One student remarked this year, "She is an inspirational figure in that she has combined mastery of her profession with a humanness that is as contagious as it is precious in medicine."

Thomas Graboys, MD, assistant clinical professor of medicine and director of the Lown Cardiovascular Center, received the fourth-year teaching award. As attending cardiologist at Brigham and Women's Hospital and serving on the admissions committee, Graboys has a great deal of contact with third- and fourth-year students. Said one student, "The lessons he taught me, which I will never forget, are about caring for patients as people. I hope that I will act like this man when I am with my patients."

Left
William Cochran

Right
Robert Schiffman

Pulse

Herbert Benson

New Mind/Body Chair

Herbert Benson '61, chief of the division of behavioral medicine and founding president of the Mind/Body Medical Institute at the New England Deaconess Hospital, has been named the first incumbent of the Mind/Body Medical Institute Chair in Behavioral Medicine, established late last year.

The new chair is the first in the field of behavioral medicine, and reflects the growing attention paid to the mind's assistance in helping the body heal. At the celebration of the chair's establishment, Dean Tosteson noted that modern molecular and cell biologists are revealing the incredible complexity of the brain's processes. "Dr. Benson has explored the unity of the mind and body, and brought insights to the sick and suffering."

Benson, HMS associate professor of medicine, is widely known for his work on the relaxation response, which he describes as the physiologic counterpart of what Walter B. Cannon (HMS 1900) called the fight-or-flight response. Over the past 25 years, Benson and colleagues at the Thorndike Memorial Laboratory, the HMS Department of Physiology, Beth Israel Hospital and now the Deaconess through the Mind/Body Medical Institute have, says Benson, "documented the basic physiology of the relaxation response as well as its usefulness in the treatment of hypertension, cardiac arrhythmias, most forms of pain, insomnia, premenstrual tension, infertility, preparation for surgery, the symptoms of cancer and AIDS, the nausea and vomiting of chemotherapy, and in cardiac rehabilitation."

The Mind/Body Medical Institute is involved in basic scientific studies and clinical investigations using the relaxation response and other self-help methods, including exercise, nutrition and cognitive therapies. It is also very active in teaching and training programs, including conducting courses for health professionals, developing curricula for schoolchildren, and offering stress management programs to the business community. "Our work now encompasses the prevention of illness and the maintenance of health, and will further the understanding of self care," said Benson.

Major funding for the chair came from William K. Coors, president and CEO of the Adolph Coors Brewing Co., who provided a matching gift, and from Laurance S. Rockefeller and other members of the Rockefeller family. Upon Benson's retirement, the chair will be called the Herbert Benson Professorship.

At a ceremony during reunion week, the Medical Education Center amphitheater was named for the late Carl Walter '32, clinical professor of surgery emeritus, who died May 5, 1992. Here, Mrs. Margaret Walter talks with Dean Tosteson, while Valerae Lewis, the 1992 Walter Fellow, and Josephy Murray '43B—both of whom spoke at the dedication—look on.

Joseph Murray

David Livingston *left* and Emil Frei III.

Murray Retires as Fund Chair

When Joseph Murray '43B accepted the call to be chairman of the Alumni Fund nine years ago, it was with "trepidation and a certain condescension." But in announcing his retirement to the Alumni Council in June, he said he had truly enjoyed his tenure and leaves with memories far beyond expectation. "I have learned so much about the pleasures of both giving and receiving money for a good cause."

As chair of the Alumni Fund, he contacted all alumni at least twice a year and worked with class agents. "The personal feedback from so many has been an unexpected and uplifting dividend." He has developed friendships from correspondence through the years and has been impressed by the diverse talent, productivity and ideals of fellow alumni.

He says he now understands how fundraising can serve the financial needs of both the alumni and the school. He realizes "the vital need for annual unrestricted gifts from alumni and the distinctions between restricted gifts, endowment, bequests and various life income trusts."

On Alumni Day, Dean Tosteson '48 expressed his gratitude on behalf of the school for all Murray's efforts, and quipped: "There is no greater gift to a dean than to have the Alumni Fund chairman become a Nobel laureate in the middle of a campaign." Murray, who is professor of surgery emeritus, shared the 1990 Nobel Prize in Physiology or Medicine with E. Donnall Thomas '46.

Murray's tenure as chair of the Alumni Fund is part of a continuum starting with the guiding force of Dorothy Murphy, and including Tom Lanman '16, Lang Parsons '27, and Carl Walter '32 before him. "In some way this is the end of an era," says Murray, "because I personally knew each of these predecessors, Carl Walter probably best of all."

As for his successor, Doris Rubin Bennett '49 will carry the torch. Alumni can now amend their list of predictable things in life: death, taxes and a twice yearly letter from Doris Bennett.

Frei Chair Filled

David Livingston, MD—who succeeded Emil Frei III as director and physician-in-chief at the Dana-Farber Cancer Institute in July 1991—has become further intereonnected with his mentor by being named the first Emil Frei III Professor of Medicine.

"It is humbling to be asked to follow in Dr. Frei's footsteps," says Livingston. "We cancer researchers owe him an enormous debt, since he showed the scientific community that heretofore unassailable forms of cancer could be controlled through rational science."

Frei returns the compliments: "David is an outstanding scientist.... My expectation is that he will continue to enhance Dana-Farber's orientation of applying basic science to clinical problems—particularly in such critical areas as tumor-suppressor genes and cell-cycle and transcriptional control, areas where David is leading the field."

Frei, HMS Smith Professor of Medicine, is credited with achieving the first cures of acute lymphocytic leukemia and with elucidating the basic chemotherapeutic principles that now form the backbone of several successful cancer treatments.

"I like to cite the unsung heroes of the fight against cancer: the patients," says Frei. "They are wonderful, courageous, and put up with a lot." In fact, it was a patient, Edward Bennett Williams, and his friends and family whose generous gifts made the Frei chair possible.

Pulse

Funding Discoveries

Inventor, entrepreneur and long-time friend of the medical school, John H. Taplin launched a new HMS program called Funds for Discovery to support young researchers. Taplin says he established the program to "identify and nurture the creativity of young faculty and assist them in transforming their ideas into technologies that will benefit humankind."

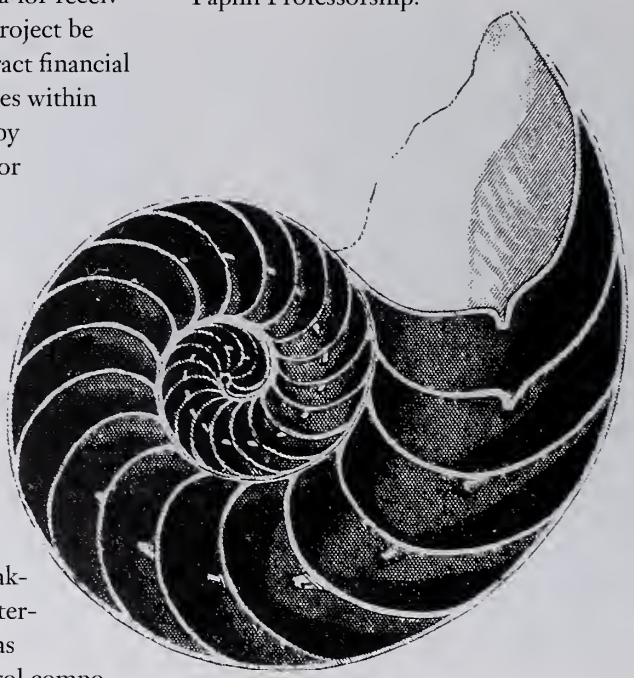
Starting this fall, the program will annually award up to 10 grants, approximately $50,000 each, to research projects that address issues of fundamental importance in human biology and medicine. Those eligible to apply for support are assistant and associate professors in the basic science departments of HMS, Harvard School of Dental Medicine and the New England Regional Primate Center. Faculty members at HMS-affiliated institutions, other Harvard schools and the Massachusetts Institute of Technology are also eligible, provided they are collaborating with an assistant or associate professor on the HMS Quadrangle.

Included in the criteria for receiving an award is that the project be innovative enough to attract financial support from other sources within one year—and will thereby likely be made available for public use. Two grants, however, may be awarded in any given year to projects that, while important, might not attract other support.

Taplin, a 1935 engineering graduate from MIT, has himself shown how technology transfer can work. His leak-free piston seal for the internal combustion engine has become a pollution-control component in automobiles around the world; he developed high-accuracy speed controls for aircraft engines and equipment to regulate air pressure levels so that passengers do not need oxygen masks at high altitudes.

Taplin credits Carl Walter '32 for inspring him over the years. Walter hired Taplin in 1945 to be chief engineer for research and development in Walter's Fenwal Company. "As the director of new product research," says Taplin, "I developed an appreciation for the importance of providing each new research project with a sufficient level of internal funds."

Funds for Discovery is the latest association of Taplin's with the medical school. He established the National Health Research Foundation, forerunner of the Funds for Discovery; he has been an associate of the HMS Office of Technology Licensing and Industry-Sponsored Research; since 1988, he has served as director of Ion, Inc., a Harvard subsidiary that participates in the venture fund Medical Science Partners; and in 1986, he and his family endowed the Edward Hood Taplin Professorship.



HMS in Amsterdam

Harvard Medical School and the Harvard School of Public Health played leading roles in the VIII International Conference on AIDS, held July 19 to 24 in Amsterdam. Not only was Harvard a co-sponsor of the conference—along with the Dutch Foundation-AIDS Conference 1992, the International AIDS Society and the World Health Organization—but among the over 10,000 attendants and 500 speakers were several HMS and HSPH faculty. Most notably, Jonathan Mann, MD, MPH, and director of the Harvard AIDS Institute's International Center, served as chairman of the conference. Max Essex, DVM, HSPH Lasker Professor of Health Science served as the co-chairman for science

The international conference initally was to be held in Boston, but was moved out of the country to protest the U.S. immigration policy that restricts HIV-positive travelers from entering the United States.

The conference was divided into four scientific tracks, two of which were co-chaired by HMS faculty: Basic Science by Joseph Sodroski, MD, associate professor of pathology; and Clinical Science by Martin Hirsch, MD, professor of medicine. HMS participants presenting abstracts in the Basic Science track were William Haseltine, MD, professor of pathology, on viral regulatory genes; and David Scadden, MD, assistant professor of medicine at New England Deaconess, on cytokines and virus replication.

Participating in the Clinical Science and Care track were Clyde Crumpaker, MD, associate professor of medicine at Beth Israel, who chaired the session on hemopoietic growth factors; Bruce Denzube, MD, instructor in medicine at Dana-Farber, spoke on new antiretroviral drugs; and Harvey Makadon, MD, assistant professor of medicine at Beth Israel, led an abstract

President's Report

by George M. Bernier Jr.

session on managing malignancies. Christopher Murray '91, clinical fellow in medicine, spoke on tuberculosis and HIV.

Below are conference highlights, perhaps overshadowed by the reports of the non-HIV cases of AIDS-like symptoms, which dominated media coverage of the conference.

The results of a survey conducted at UCLA about residents' willingness to treat AIDS patients were reported: out of the 1,745 residents surveyed in the United States (2,648 total in 10 states, France and Canada), 23 percent reported that they would choose not to care for a person with AIDS.

UC/San Francisco reported on the dramatic increase of HIV infection among women. For example, 10 percent of the women of childbearing age in Brooklyn, NY are HIV infected—the same percentage of women in some African countries.

The newest statistics on HIV infection were reported by the World Health Organization: 10 to 12 million adults and 1 million children worldwide; 50 percent of the adults, WHO estimates, are women. Jonathan Mann predicted that by the year 2000, total infections would rise to 140 million.

CDC reported on its study indicating that parents who are educated about AIDS are more likely to inform their children. Janine Jason '75 from the CDC said that pediatricians make effective AIDS educators for parents.

The National Institute of Allergies and Infectious Diseases (NIAID) reported that large-scale human tests will begin in the next few years on one or more of several experimental vaccines. The Agency for Health Care and Research declared that the lifetime cost of caring for a patient with AIDS has nearly doubled, from $57,000 in 1988 to $102,000 in 1992, with an annual cost of $38,300.

The year for the council of the Harvard Medical Alumni Association began with discussion of the physician satisfaction questionnaire, which concluded that most alumni of this school were indeed satisfied overall with their careers in medicine. Most graduates, however, identified areas that needed improvement.

One area of grave concern has been expressed by recent graduates in particular, and that is the increasing and oft times staggering level of debt incurred by the time of graduation. Graduates enter their residencies with accumulated debts that approach, and in several instances exceed, $100,000, a figure that triples when debt service is accrued.

At this time last year, the council suggested to Dean Tosteson that a task force of individuals with diverse backgrounds—lawyers, bankers, economists, as well as physicians—study the problem. Dean Tosteson assembled a blue ribbon group, which has included, along with a stellar cast of financially oriented individuals, three members of the council—Nancy Rigotti '78, past president Bob Goldwyn '56, and me as chair. The group has met on several occasions during the past year and will report to the dean and the council at its meeting this fall.

We have concluded that the high level of indebtedness of our graduates is a very serious problem, that the problem is increasing, that it impacts the matriculation of accepted students, and that debt burdens have become a determinant in shaping careers for some of our graduates. We have agreed that barring a revolutionary change in governmental health financing, no single solution to this problem is likely. Instead, a series of partial remedies will be prescribed or recommended. These include changes at the medical school level, such as tuition control and low-cost loans creatively financed; changes at the hospital level to accommodate and help manage the burden that graduates bring to the residency years; and changes in state and national policy, which would tie debt forgiveness into careers deemed high priority and to service in areas deemed underserved.

We are not unmindful that this problem is not uniquely Harvard's. It is our hope that solutions that are applicable here will have a broader impact on the way that medical education is financed nationally.

The second initiative, which has been led by Lisa Guay-Woodford '83, is also student-focused. It involves the establishment of a network of alumni in cities outside New England to provide opportunities for fourth-year and graduating students to contact more established alums. This will begin on a pilot basis this fall in five areas. We look forward to Lisa's report on this activity next year.

It has been an honor and a pleasure to serve as your president this year and I thank you for granting me the opportunity. I wish Will Cochran '52 great success as the incoming president of the Alumni Association. I know that he will take the council to new heights.

George M. Bernier Jr. '60 is dean of the University of Pittsburgh School of Medicine.

Enhanced Role for Societies

What was the new is now the common pathway of general medical education at Harvard Medical School. After seven years of experimentation and development, what was known as the New Pathway will now simply be called the Program in Medical Education.

But there is really nothing "simple" about what has happened and is happening to the educational process at HMS. Though much of the science and clinical education remains familiar, it is now cast in new modes of teaching and learning. And all students now belong to one of five academic societies—each with its own faculty—through which Dean Daniel Tosteson '48 envisions the framework for continually and creatively renewing medical education to keep it relevant as changes occur in science and practice.

Over the summer the dean announced changes that will decentralize medical education, placing greater authority and autonomy in the hands of the five individual societies, their masters, faculty and students. He named new masters of the academic societies—the Oliver Wendell Holmes Society, the Francis Weld Peabody Society, the William Bosworth Castle Society, the Walter Bradford Cannon Society, and the Health Sciences and Technology (HST) Society. And to keep emphasis on general medical education, strategies were developed to provide greater recognition and compensation for teaching.

Dean for Medical Education Daniel Federman '53 puts into perspective what's happening: "Academic medical centers have grown into huge complexes that involve patient care, research and teaching—not just of medical students, but of residents, fellows, all sorts of technicians, specialty nurses, etc." Taken as a whole, the HMS faculty spends 60 percent of time doing research, 30 percent on patient care, and 10 percent on education—5 percent for graduate education and 5 percent for general medical education.

"We're not trying to gain more time than that 5 percent for teaching, but we want to rethink the *process* of education in a changing world, and create a structure that provides a locus for planning and re-examining what goes into that 5 percent."

Dean Tosteson provided the creative vision back in 1982 for a new medical education process that would better prepare students with the attitudes of respect and caring, the skills of doctoring, and the foundation of knowledge that all physicians must have. Innumerable faculty, students and others have contributed enormously to the development of an educational program that focuses on small-group, problem-based learning, with less emphasis on lectures and memorization. Basic science and clinical material are now interwoven throughout the four years, with greater emphasis on the social sciences, ethics, and the humanity of care.

Along the way there have been things that did or didn't work, a reluctance to change, fear of the unknown or what might not get known. But follow-up studies indicate that the experiment seems to be working. New Pathway learners tend to memorize less and conceptualize more, and are generally more satisfied, stimulated and challenged.

Those who have been involved in the planning now wish to ensure that this Program in Medical Education itself does not stagnate. By decentralizing decision-making, they want innovation to be the new status quo. As of this fall, the society will be a locus for curriculum evaluation and innovation. The masters will now be more like department heads, with their own budgets, and thus be able to recompense teaching, promote greater faculty/student mentorship and involvement, and in general accomplish more independent goals and student activities. A day is envisioned when one is not only an alumna or alumnus of HMS, but also of the Peabody Society, the Holmes Society, and etc.

"Within the bounds of the requirements for a medical degree," says Federman, "each society will have the freedom to try something different, which, if it works, the other societies may or may not adopt." But Federman quickly points out that the dean's emphasis is that each course not be an isolated experience, but rather regarded as integral to the four-year course of study, ensuring what planners are calling the "vertical integration" of the curriculum.

Societies are not intended to be differentiated by specialty, career intent or personal background, says Federman. There won't be one that concentrates on primary care or another for research.

So, specifically, how might any one master and society innovate? At present, Federman responds, all lectures are common to the four non-HST societies; it is in the tutorial portion of each course where approaches can be differentiated. "One society might, in a given course, decide in its tutorial—in addition to conveying all the required science—to emphasize public policy or ethics or economics. It represents an enrichment of their tutorial."

Societies may develop new elective courses, "although even the core curriculum is not immutable. The way a society might meet the Advanced Basic Science requirement is individual. There will probably be innovations in

the three-year Patient/Doctor sequence, or in how renal and cardiorespiratory are taught in the Human Systems block, or there may be a new approach to teaching pharmacology or genetics and reproduction."

There is still the central Curriculum Committee, which approves and oversees curriculum offerings. But now that committee comprises the masters, faculty and students from all five societies—people, as Federman says, who have an innovative bent, who are willing to give something new a try. The societies are meant to provide a more intimate experience, where educational goals of the individual student are the primary focus. A recent trend, Federman points out, is that 40 percent of students don't graduate in four years; they do other things, such as research for a year, get other degrees, or go on traveling fellowships.

"The student, for example, who knows she wants to get an MPH can work with faculty in her society to plan and adapt her course of study," says Federman. "Society faculty should know students better and connect with them. Good advisors have always done this, but in the societies, every student has a chance to pull from the faculty in his or her society an aggregate expertise in an area of interest that is greater than any one advisor could provide."

There is some anxiety among the students, Federman acknowledges, about excessive differentiation. No one wants to miss out on anything. But Federman points out that any innovations that work can be adapted by other societies. "On the whole, students have welcomed the tutorial approach and the framework of having a master and faculty whom they get to know well."

Broad faculty participation in the societies has been sought and a concurrent attempt made to tackle the age-old problem of inadequate compensation and academic rewards for teaching. The new masters will each have budgets, in part to compensate faculty for time spent on medical education. Since 1989 a teacher-clinician track toward tenured appointments for faculty has recognized the contributions of those whose primary activity is teaching.

And who are these new masters, who as of July 1 have been guiding their societies through the shoals of change? Some of the names are familiar: Ronald Arky, MD, the Charles Davidson Professor of Medicine and chief of medicine at Mt. Auburn Hospital, will remain master of the Peabody Society; Stephen Krane, MD, the Harrison Professor of Clinical Medicine and head of the MGH Arthritis Unit, will continue as master of the Cannon Society; and Daniel Goodenough, PHD, the Takeda Professor of Anatomy and Cellular Biology, returns to to the position he had from 1985 to 1989 as head of the Holmes Society, the prototype for today's societies.

Newly appointed are Marian Neutra, PHD, professor of pediatrics at Children's Hospital, who is now the master of the Castle Society; and Michael Rosenblatt '73, who came back to HMS in March as the HST Society master, and the Ebert Professor of Molecular Medicine.

Ellen Barlow

Class Day

There was a great deal of merriment and sunshine on June 5 as the 157 members of the Class of 1992 commenced their lives as "real" doctors. Everyone stood as the procession entered the tent, the soon-to-be graduates waving to their loved ones. Class co-moderators Kelli M. Bullard and Robert C. Lowe expressed thanks to all their mentors and classmates, and most of all to their families, who are probably "just glad we are finally getting a job," said Lowe.

The students addressed the audience first. Marc J. Laufgraben stepped to the podium with a camera and asked everybody to wave, "for future generations of Laufgrabens." He talked of possible role models for a successful career in medicine—from his childhood role model Leonardo da Vinci, to Rip van Winkle, who enviably got to sleep for 20 years, and finally to a composite role model, "Dr. Bo," who knows everything, whereas "you know nothing." At one point he mentioned the parking situation at HMS. As he turned to the dean, Laufgraben said the administration's solution was simple: "No parking, no problem." The dean grabbed Laufgraben's camera and pretended to photograph him, to the delight of the audience.

On a more serious note, Joseph Rhatigan likened his medical education to a treasure hunt, where the real treasures turned out not to be the glittering, obvious ones. They were the intangible things he and his classmates had learned: how to handle fear, how to deal with pain and suffering, and what it means to be a doctor. His classmates honored him with a standing ovation.

Tennis champion Arthur Ashe started by describing how he came to be the last-minute HMS commencement speaker. While riding in a New York taxi, he read in the newspaper that Magic Johnson had cancelled because he wanted to be with his wife when their baby was born. "I would like to say a few words to those medical school graduates," Ashe said to himself, and found a phone and volunteered.

He based his advice to the graduates on 13 years as a "professional patient"; since a heart attack in 1979 and now AIDS, he has acquired a cardiologist, a neurologist, a neurosurgeon, a cardio-thoracic surgeon, a dermatologist and an infectious disease specialist. He urged greater empathy and connection on a human level with patients: "When I see my doctor, I would rather his or her first question be, 'How's your daughter doing?' as opposed to, 'Where does it hurt?'" He mentioned some of the ethical questions that AIDS has brought out, and urged the graduates to enter the fray and become part of the debate.

Lewis First '80, assistant professor of pediatrics at Children's Hospital, brought his characteristic humor to the day. "I am honored to be the pediatrician present in this makeshift delivery room we call the graduation tent and to be assisting in your birth into the world of medicine." He continued his analogy by describing the four developmental milestones that the newborn physicians must pass on their way to successful careers: the gross motor milestone of endurance, the fine motor milestone of balancing professional and personal lives, the language milestone of effectively communicating with patients, and the social milestone of commitment to social issues and to each other.

First was also the recipient of the students' clinical teaching award; the preclincial teaching award went to Steven Weinberger, associate professor of medicine at Beth Israel. The co-moderators then presented a "Friend of the Class" award to Edward Hundert '84, associate dean for student affairs.

In his first commencement as dean of the Harvard School of Dental Medicine, R. Bruce Donoff '67 conferred degrees on 16 HSDM graduates. This year is also the 125th anniversary of the founding of the dental school.

The medical students got theirs, and before repeating the oath that would make it official, the new doctors listened to Dean Tosteson's valediction. He cited some of the immense changes the world has undergone the past four years they've been in medical school. But, "what has emerged from the end of the Cold War has not been reassuring about the current status and likely future directions of human society. Rather, the reduction in global terror has revealed in stark detail the intensity of racial and ethnic animosities throughout the world." The dean urged graduates to assume special responsibility in understanding the origin of these animosities and in promoting more tolerance.

Thirteen students graduated cum laude in a special field, six magna cum laude, one summa cum laude, and eight were honored with prizes or awards:

Jonathan S. Bogan, summa cum laude
Leon Reznick Memorial Prize for excellence and accomplishment in research: "Genetic Mapping and Molecular Biology of the Human Y Chromosome."

John S. Cameron, cum laude
"The Analysis of the Interleukin-3 Gene Promoter by In Vivo Footprinting."

Constance Ren-tien Chu, cum laude
"The Vascular Response of Healing Flexor Tendon Grafts within the Digital Sheath."

Nam Hoang Dang, magna cum laude
"Aspects of CD_{26} Involvement in Human Thymocyte and Mature T-Cell Activation."

James Chung Yu Dunn, cum laude
"Development of a Bioartificial Liver."

Alik Farber, cum laude
"The Biologic Behavior of a Non-immunogenic Murine Tumor Modified by the Insertion of the Gene for TNF-Alpha."

Peter K. Kaiser, magna cum laude
Sirgay Sangar Award for excellence and accomplishment in research, clinical investigation or scholarship in psychiatry: "Central Neuron Injury Secondary to the AIDS Virus Envelope protein gp120, and its Prevention by Calcium Channel and NMDA Receptor Antagonists."

Sang-mo Kang, magna cum laude
Henry Asbury Christian Award for notable scholarship in studies or research: "Interleukin-2 Gene Regulation in Non-Transformed T-Lymphocytes."

Dara Kim Lee, cum laude
"Left Ventricular Hypertrophy in Black and White Hypertensives: Racial Differences in Diagnosis and Prognosis."

Lawrence Hong Lee, cum laude
"Retroviral Oncogene Induced Growth Deregulation of Murine Helper T-Lymphocytes."

Vivian Shu-Ching Lee, cum laude
Rose Seegal Prize for the best paper on the relation of the medical profession to the community: "Visual Impairment in Diabetic Oklahoma Indians."

Mark B. McClellan, cum laude
"Appropriateness of Care: A Comparison of Global and Outcome Methods to Set Standards."

Ben L. Nguyen, cum laude
"Mechanism of Nitric Oxide and Cyclic GMP Inhibition of Signal Transduction in Activated Platelets."

Alexandra E. Page, cum laude
"Cortical Strain Analysis of Long-Term Remodeling Around Cementless Hip Prostheses in a Canine Model."

John K. Park, cum laude
"Role of CD43/ICAM-1 Interactions in T-Cell Activation."

Dale S. Reynolds, James Tolbert Shipley Prize for excellence and accomplishment in research: "The Molecular Biology of Mast Cell Proteases."

Tanya M. Rutledge, magna cum laude
Harold Lamport Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: "Zeta Chain Dimerization & Functional T-Cell Antigen Receptor Association: Trans-Membrane Charge Mediated Phenomena."

Miriam Anne Schizer, cum laude
"Measurement of Serum Levels of Basic Fibroblast Growth Factor in Oncology Patients."

Jordan W. Smoller, cum laude
"Molecular Genetic Approaches to the Study of the Fatty Mutation in Genetically Obese Rats." Richard C. Cabot Prize for the best paper on medical education or medical history: "Cynicism and Medical Education."

Darryl A. Tannenbaum, magna cum laude
"Cloning, Expression, and Preliminary Characterization of Recombinant Alternative Isoforms of Latent TGF-B2."

Jane M. Yang, magna cum laude
"Molecular Mechanisms in the Regulation of the Heme-Regulated eIF-2∂ kinase (hri)."

Tremendous Tasks Ahead

by Arthur Ashe

WHAT MIXED EMOTIONS YOU MUST have today! As of today, you are to be addressed as "Doctor..." I too have mixed emotions. For if I, an AIDS patient, came to you, some of you graduating today wouldn't treat me—if I may be allowed to loosely project onto you the attitudes of some practicing physicians.

However, I come before you as more than just someone with AIDS. I come as a 13-year professional patient. My AIDS condition is only one of many health problems I've had and is but one of many health care issues you will face as you begin your internships and residencies.

The doctor/patient relationship is one topic that I'd like to dwell on for a few moments. As an athlete in a sport like tennis, I was fortunate to travel internationally and could compare our American approaches to many problems with approaches in other parts of the world. Health care in America always made for a lively discussion for one primary reason: relatively speaking, it's more expensive than anywhere else.

It was not unusual in the locker room to hear my fellow players from Pakistan, Japan, Hong Kong, Australia, Western and Eastern Europe, South America and even Haiti speak of the healing process. Amidst the talk of managed care, which we hear so often now, I remember hearing once what was for me a fascinating idea. In ancient China, it seems, people paid their physicians as long as they remained well. As soon as someone got sick, he or she stopped paying. They paid the doctor to keep them well rather than to treat them later. Maintenance, not cure, was what was paid for. Of course, that is one of the concepts behind HMOs.

I refer to myself as a professional patient because since my heart attack in 1979, I've acquired a cardiologist, a neurologist, a neurosurgeon, a cardiothoracic surgeon, a dermatologist and an infectious disease specialist. Two of my best friends are doctors: one is an ob-gyn; the other, a surgeon and hospital owner. My wife's best friend is an ob-gyn specialist whose entire practice is with indigent women who are HIV-positive. I also have a dentist whom I like a lot, and who lost some patients when they found out he had been treating me. Having had a heart attack, two open-heart surgeries, one brain surgery, and various other prods and pokes—including a spinal tap after brain surgery, which I was not too thrilled about—I feel I'm qualified to impart some advice.

As coincidence would have it, the front page of this morning's *New York Times* headlined, "In Lessons on Empathy, Doctors Become Patients." Four New York City hospitals felt the problem of inadequate doctor/patient relationships was so acute that they spent $1 million videotaping encounters of medical students with fake patients and then following up with counseling. Actors and actresses surreptitiously played the role of patients, and the students later critiqued their own performances. I thought this article was so important that I rewrote my speech this morning to include it.

You must listen to your patient carefully, and that is not as easy or as simple as it sounds. No matter who you are or what your family's ethnic or cultural background, you may be tempted to use one set of assumptions in communicating with everybody. The white, middle-class paradigm won't work with everyone—and by this I don't mean that you should just learn a little Spanish. There should always be a little time for just connecting on a human level with a patient.

The lessons in empathy described in the *New York Times* article also reminded me of a book I read almost a decade ago, entitled *Megatrends*, by John Naisbitt. In it he describes what he thought then would be 10 major, or mega-, trends influential in American life in the next decade or so, thus coming into vogue right now.

One of these trends is labeled "hi-tech, low-touch," meaning that as technology races ahead of any solid consensus on how to use or regulate it, people like you at Harvard Medical School will be evermore tempted to seek solutions through machines rather than personal contact. This is the dilemma that the $1 million expenditure by New York hospitals was trying to address. I know I'm not your ordinary patient, but first and foremost, when I see my doctors, I would rather his or her first question be, "How's your daughter doing?" as opposed to, "Where does it hurt?"

Now let me take off my hat as professional patient and put on the one with the green plastic visor on it: American citizen, bean counter or payer of our national health care bills. Right now, as I'm sure you know, about 13 cents of every dollar spent in America goes to health care in some form. That may be 20 cents by the year 2000—who really knows! The point is that you as physicians are probably looking at some salary or fee caps in a few years. The two cost components in the typical American family's budget that continue to increase faster than inflation are higher education and health care.

We as a nation absolutely must get the rate of increase in health care costs down to reasonable levels. In concert with other solutions, you will be asked to play your part. As a 10-year board member at Aetna Life & Casualty Co., one of the world's biggest carriers, I am very familiar with such matters as reimbursement fraud, and the padding of hospital bills of the insured to pay for those who are uninsured. I am also aware of the occasional practice among doctors to suggest a procedure in fear they will be sued for malpractice later. Or, how some doctors may suggest a procedure and not inform the patient that he or she is also part owner of the firm that administers the procedure. These are examples of how our society is increasingly driven by technology, and how the parallel code of ethics attending the new technology consistently lags behind.

More and more you will be faced with new ethical dilemmas and challenges. I would ask, by what moral principle would you refuse treatment to an AIDS patient? Many of you might answer with nature's first law of self-preservation. But I do not believe that's a good enough answer. You are supposedly the most well-trained new physicians extant. If you're not, and for what you paid in tuition here, you certainly should be. The AIDS problem needs your attention.

"This AIDS thing," as I refer to it, will certainly test your resolve, your ingenuity and creativity, and your patience. Until Dr. Jonathan Mann made front-page headlines this morning with a sobering new update on the spread of this pandemic, I felt there wasn't sufficient comprehension of the staggering scope of this worldwide problem.

Living in New York City as I do, I shake my head in frustration as debates with no resolution continue as to the ethics of, for instance, distribution of clean needles to IV-drug users and condoms to high school students. As Dr. Mann's report makes clear, the total number of AIDS cases to be documented in the next three years will

exceed the combined report totals during the entire history of the disease. Meanwhile, officials in New York City, worried about being politically and morally correct, are wasting time arguing over the weight and relative emphasis given to "abstinence" versus "safe sex."

What does this mean for you? You must enter the fray. You, as healers, must become part of the debate with some perspective gained from courses in bio and medical ethics, which I know you have taken.

Lest I be accused of shying away from the debate of abstinence versus safe sex, or clean needles versus wishful thinking, my opinion is this: if condoms are handed out on demand as isolated acts, not as part of an organized program of sex education, then I believe that is a problem. The alternative, as Dr. Mann points out, is an international health care bill that could become, quite simply, unmanageable—meaning moral decisions will be made to just let people die. I do not postulate this solely because I am an AIDS patient (I resist the description or descriptive use of the word "victim").

You truthfully are a unique group of medical school graduates, who face a challenge unlike any of your predecessors. Like it or not, the world is looking to you for answers. If ever the phrase "global village" more aptly describes the scope of your medical practice, then this is it.

While Dr. Mann spoke of the enormity of the pandemic, its effect on everyday life was, in this article, underreported. If his estimates are correct, even within a 10 percent margin for error, there will develop a popular mandate to "do something." Well, doing something will require cutting back on research for other diseases. Doing something may make that 20 cents of every dollar in the American economy by the year 2000 a severe under-estimation. There will be more pressure to curb or contain your fees for service. And this will certainly cloud what is already a raucous debate on the idea of national health service.

Let's go back to basics. If I ask you hour-old grads of Harvard Medical School today to describe America's policy on health care in 50 words or fewer, what would you say? While you're thinking, here's mine: Through a prudent combination of federal assistance and private enterprise, America will ensure appropriate, adequate and sufficient physical and mental health care for all its citizens. Furthermore, America acknowledges its preeminent moral position in leading combined global efforts to assist, share information, and seek solutions for our common medical concerns. Fifty words.

Some last thoughts about the concept of health. There are four pieces to my jigsaw puzzle of personal well-being: access to doctors like you; availability of prescriptive and nonprescriptive drugs, therapies and treatments; the support of family and friends; and for me most important, personal initiative. If any of these is missing, I've got a problem.

Implied in all this is that the general health of the American people is of prime importance to us all. You graduates are to the medical profession what a West Point graduate is to the U.S. Army. From you, to whom more was given, more is expected. Not only with your state-of-the-art technical knowledge, but as it is written, "With all thy wisdom, get understanding." If you understand me, or your patients, appropriate treatment decisions will be easier.

Finally, the AIDS pandemic is but one of many lifelong challenges you will face. Some of you will volunteer to accept the tremendous tasks ahead. Some of you may, in time, drop out of medicine because you'll burn out. However, and whatever you do, I want to wish you well.

Peabody Society Master Ronald Arky and Marilyn Mon.

Arthur Ashe is a former tennis champion, having won both the Wimbledon and U.S. Open tennis championships. He is the author of A Hard Road to Glory, *a book chronicling the history of black athletes in America, for which he won an Emmy Award for writing when it was adapted to television. He is a television commentator and host of the TV series "The Other Side of Victory," and he has been a leading supporter of the anti-apartheid movement in South Africa.*

Developmental Milestones

by Lewis R. First

HAPPY BIRTHDAY TO THE CLASS OF 1992! I am honored to be the pediatrician present in this makeshift delivery room we call the graduation tent, and to be assisting in your birth into the world of medicine.

I know that some of you are feeling that your birth today is a bit premature, and perhaps a few of you, particularly those of you who stopped off for a PhD degree along the way, are feeling overdue for your delivery. Hopefully everyone attended all the required prenatal classes, otherwise known as your 5,235 tutorials, over the past four or more years. Otherwise, it's possible that your birth today is going to be somewhat traumatic. Nonetheless, it's about to happen.

Most of the time, it is the responsibility of the pediatrician in the delivery room to assign a viability rating, known as the Apgar score, on each newborn. This score gives points for such things as how fast the baby's heart is beating or how well the baby is breathing, with a maximum being a score of 10. Yet studies have shown that a good viability score does not prognosticate much more than getting out of the hospital, or this tent, as quickly as possible.

What matters after this moment of medical birth is insuring that you make the most of your life and the career that awaits you. How can this be done? You do this by monitoring your own progress over the years ahead in terms of achieving certain goals, or as we say in pediatrics, some developmental milestones—milestones that as a pediatrician I am going to review with you today, just as I do with all my patients and their families who are ready to leave the nursery.

Now development, as you may recall, revolves around four types of skills that begin in infancy and continue throughout life. No, not eating, burping, stooling and drooling—although these certainly do continue throughout life—but rather gross motor, fine motor, language and social skills. These are the milestones I'll be discussing and that must be mastered over the next few years in order to fulfill the obligation of becoming a true physician.

Let's start with the gross motor milestones, which to some may be the easiest to achieve. "Motor," of course, signifies movement or activity, and "gross"—from the first moment in anatomy, you had a sense of "gross." This sense will continue as you enter the hospitals, perhaps as you experience the joie de draining a perirectal abscess or examining a scalp for head lice.

A gross motor milestone for me occurred when, as a senior resident, I decided to do some bedside teaching, and led my team of residents and medical students to the bed of a five-year-old-girl admitted for asthma, who was not getting better on our routine therapy. As I stood there pontificating on the differential diagnosis, she proceeded to cough up a rather cute, but not so cuddly, worm. Now you might think upon seeing that worm that the motor milestone I achieved was the ability to run away as quickly as possible, but it was not. It was the ability to stop right there to comfort the patient, who was certainly surprised; the intern and medical student, who had both fainted; and the worm, who got an all-expense paid trip to our microbiology lab where it could receive proper diagnostic attention.

While the ability to stomach some of the more nauseating aspects of our profession does represent a "gross" developmental milestone, I would like all of you, as you begin your residencies, to consider another gross motor milestone—and this time the emphasis is on the word "motor"—to describe your constant movement and activity in the years ahead, otherwise known as endurance.

You may think that you have conquered the endurance milestone when you have stayed up all night and all the next day caring for patients. Unfortunately, this represents a misconception of how to address the endurance issue, and is certainly not in the best interest of the emotional needs of the patient or of yourself. What will allow you to triumph over endurance is not your ability to go on, but rather your ability to stop after being up all night, and to hand over the care responsibilities to someone less exhausted than you are.

As many of you probably know, the death of a woman named Libby Zion in the emergency room of New York Hospital in 1984 ignited many provocative issues regarding the duration of resident work hours, and the ability of residents to provide competent medical care when sleep-deprived. As a result of this case, the New York

commissioner of public health even appointed a commission, known as the Bell Commission, to study these issues.

The Bell Commission, as you may have read, recommended limiting the duration of resident hours per call day and per week in the state of New York. As a result, some now argue that by fixing the maximum number of work hours, the exhaustion problem for a resident has been solved. Others, however, counter that these regulations may be simultaneously hampering the doctor/patient relationship, as patients begin to see their doctors as time-shift employees rather than as continuity-of-care providers (and sadly, doctors on this schedule may feel likewise). These are controversial issues, which remain unresolved and are undergoing study.

One needs to look therefore at the issue of endurance and ask if there's another way to deal with the problem? I think the answer is yes, and that is the gross motor milestone you must all achieve—the ability to not only delegate responsibility to someone who is less sleep-deprived than you, but more importantly, if no such person exists, to step forward within your residency program and advocate with your program directors for more humane training conditions.

Innovative ways to do this are being used in residency training programs scattered throughout the country. Some programs, for example, have created a night float system. By night float I am talking about a second- or third-year resident who comes on duty late at night to admit patients so that the day crew can catch up with their work and get some rest. The night float then goes home in the morning to sleep while the day crew, now rested and ready to go, takes over.

Other programs have attempted to increase their number of residents to decrease the patients per doctor ratio, although this is easier said than financially done. A few programs have even removed some patients or floor units from the domain of their residents' schedules to reduce the fatigue burden. Regardless of how you do it, mastering the gross motor milestone of endurance is an important one to conquer early in your medical life, if you don't want to experience burn-out, chronic fatigue and frustration with the complex and challenging career ahead of you.

What about the other developmental hurdles that you must encounter? Let's turn now to fine motor milestones, which require you to demonstrate some coordination and achieve an intricate balance in order to advance developmentally.

I remember one night during my residency when one of the Boston Celtics brought in his three-year-old son, who had severe difficulty breathing. The child appeared comfortable riding on his father's shoulders, but each time we lowered him onto the exam table, he screamed to the point where he would almost stop breathing from bronchospasm. Not wanting to worsen the situation, I suggested that he climb back onto his father's shoulders, and then I went and got a stepladder from which I balanced meticulously while trying to listen to the child's lungs from eight or nine feet above the floor.

While I do not expect many of you will need to assess your patients while balancing on a ladder, there is a different kind of balance that one must struggle with, which perhaps began with your experiences in medical school, but will intensify from this point on. That is the balance between the hospital and your personal life. Inability to achieve this balance results in stresses that will impact your patients, your peers, your family, your friends, and most of all yourself. Furthermore, inability to achieve this milestone is probably also a strong contributor to the creation of the impaired physician that we hear so much about: a physician who suffers from depression, or one who turns to drugs or alcohol from failure to achieve personal success as a result of stresses, either with home or career. On the other hand, when you conquer this milestone successfully, there is no greater feeling of accomplishment.

So how do you do it? You would like to think that both your hospital and your supports outside the hospital understand each other, and oftentimes they do. Many residency programs are offering support groups for their residents that focus on everything from handling the difficult patient to the stressed spouse or significant other. But you can't expect a training program to conquer this milestone for you. After all, a training program has service needs, schedules to be filled, and only a finite number of bodies to do it. And if you ask a training program where their priority is, they will probably tell you that maintaining a balance for an individual resident between personal life and career is something that must be discussed, but it must be discussed just as soon as rounds and conferences and clinics are over (which, as you know, they never are).

Let me turn now to all of your family and friends—who are assisting me at your delivery today—and congratulate them as well at this moment of birth. As my assistants, you have gone above and beyond the call of duty in making this delivery as free of complications as possible. Yet, unlike the obstetrical team in the operating room, your job is not done once the labor and delivery of your graduate are complete. It is really just beginning. If ever your graduate is going to need your support, it is in the years ahead. My wife and son can attest to this, and to them I am eternally grateful.

For those of you graduating today, your family and friends can only do so much to help you straddle that fine motor line that balances your life, particularly if you are too tired to even recognize that they are trying to understand and sympathize with your ordeal.

So how can you conquer this fine motor milestone? My solution is a simple one, but again is dependent not only on your training programs or on

your family and friends, but on all of you graduating today. The best way to achieve a balance between your personal time and career is to insure that both aspects of your life learn more about each other.

Encourage your residency programs to have social events not just to welcome you to three or more years of hard labor, or to congratulate you upon finishing such labor, but throughout your training. This allows your supports to meet others going through similar situations. Some progressive residency programs around the country are even sponsoring support groups and retreats for spouses and significant others.

If child care demands arise, the whole concept of part-time residencies or shared residencies (which are few and far between) should be introduced to your program directors if they have not been already. These programs are essential and worth fighting for. After all, a hospital has many doctors it can rely on, but your family and supports just have you. If you realize the importance of fine-tuning the balance between your life inside and outside of the hospital, you will have mastered yet another major developmental milestone needed to achieve satisfaction with your career and preserve your own mental health and well-being.

The third area of development that all of you will need to tackle is your language skills. This is not as easy as you might think it would be at this point in your training. After all, four years plus at Harvard Medical School have allowed you to med-speak with the best of them. Abbreviations like "BR with BRP" (bed rest with bathroom privileges) are second nature to most if not all of you graduating today. The third, fourth, and eventually fifth generation cephalosporins will flow like water off your tongue and into the mouths and veins of patients. Yet the more comfortable we get with our roles in medicine, the more oblivious we become to the fact that not everyone understands our medical vocabulary.

Rubencio Quintana and friend.

For example, I cannot forget explaining to a mother and father, who were both also graduate students, what to do for their infant who had a cold and ear infection. I recommended salt-water nose drops for the baby's nose and an antibiotic for the ear. I even thought I would save the family money by telling them they could make their own nose drops by mixing a half-teaspoon of salt in eight ounces of water, and then inserting the drops into the baby's nose after meals and before sleep. As to the ear infection, I recommended the antibiotic be given as one teaspoon three times a day for ten days.

You can only imagine my surprise when I got beeped several hours later to hear the parents say, "Dr. First, we've gotten four ounces down the nose; do we have to drop in the whole eight ounces of salt water?"

After the child and I recovered from the closest thing to a salt-water drowning, I patiently reviewed with them that you only need to give two or three drops at a time in each nostril and then throw the rest of the water away—something I had assumed they would understand implicitly in my discharge instructions.

Two days later the family called to say their child's nose was better but the ear remained a problem. All they could report was that the antibiotic was staining the ear pink each time they poured it in. I took a deep breath and reviewed with them the administration of the antibiotic by mouth. This incident was sobering for me, since if graduate student parents could not follow what I thought were routine discharge instructions, I could only imagine what was happening in the homes of other families I was caring for.

So what is the language milestone that needs to be achieved this time? Keep it simple and assume nothing. It seems like common sense, and maybe it is, but if all of us were doing it, maybe we would be much better at educating our patients, not only about their treatment regimens but about areas of prevention.

Maybe the outrageous statistics we are seeing about teenagers practicing unsafe sex derive from our inability to clearly pitch prevention at a level where the audience understands it and can identify with it. I'm not suggesting you talk down to patients, but I am suggesting that you take some time and learn where a patient is at, not only with a review of symptoms, but by learning interviewing and teaching techniques that allow these families to

better understand you and vice versa.

Try this experiment. Have your patients tell you what you just told them. See if it differs from the message you thought you had given to them. Listen carefully not only to their symptoms, but to how their medical problems will impact their daily lifestyle, or how their lifestyle can impact on their medical well-being. It will take a few more minutes, but with that extra time, those patients will be much more likely to have heard you and will better understand what you are trying to do for them, both now and in the future as their health care provider.

Ask your program directors to devote time to demonstrating effective teaching techniques and communication skills as part of your residency training. These skills will be your most powerful tools and will not change with advancing technologies. Interviewing and teaching workshops do not have to stop with the patient/doctor courses, but it's up to you to take the initiative. Otherwise, we may find more patients with glasses of salt water down their noses or pink medicine in their ears.

Finally, I turn to social milestones, and here expectations run high, although the reality is less so. What do I mean by social milestones? At a fundamental level, they require gaining some awareness of other people's concerns, not just your own. For example, I will never forget as a medical student my first senior resident in pediatrics.

It was a dark and dreary day in February as we started rounds on the infant ward. Everyone seemed grumpy—doctors, nurses, even patients—and the residents seemed especially burned out and exhausted. My senior resident arrived to begin rounds with all the symptoms and signs of a bad cold. A concerned nurse told him that unless he wore a mask, he would be infecting other infants on the floor and could not lead rounds.

The senior resident shared the nurse's concern, but he was also concerned for the well-being of the medical students and residents on his team, not only from the standpoint of infection control, but also our morale. He therefore got someone to keep an eye on the patients, gathered our team of residents and medical students, and told us we were going on a field trip.

Next thing we knew we were on the MBTA headed downtown. Our destination was kept a surprise until we walked through the doorway of Jack's Joke Shop. Our senior resident then proceeded to buy each of us a mask—not the kind you usually see in a hospital, but ones that appear more often on Halloween. I remember the senior bought the most elaborate, which had eyeballs dangling on two springs.

We arrived back to finish our rounds in full regalia and delighted infants, parents and even nurses with the fact that in the gloom of winter in New England, you can still have a sense of humor. The dangling eyeballs even served as ideal distracters, allowing us to get quiet and cooperative exams from the infants and toddlers on the floor.

Your need to concern yourself with the social well-being of not only your patients but also yourselves is the first social milestone that must be conquered. Keep an eye (not necessarily a dangling one) on each other while going through residency, fellowships and life thereafter. Think of things that will not only help you, but help others in the environment in which you are practicing.

My residency group, for example, used to hold "theme nights" on the evenings we were on call. Everyone in the hospital would get together around midnight for Joke Night or Crazy Sock Night (which could be worn discretely underneath our scrubs). We may not have been better than other residents medically, but we were certainly top of the line when it came to high morale as we underwent our residency training. We conquered this social milestone by caring for each other.

Yet, being socially concerned about ourselves as physicians is not the most difficult milestone ahead of you. No, the social milestone that will be hardest to tackle and yet the most fulfilling is your taking an interest in a social cause that you think is worthwhile—even if it has no direct bearing on the patient in the next bed you are expected to see. Some of these causes, such as reducing domestic violence, teen pregnancy, abuse of the elderly, or homelessness, seem too enormous to even begin to tackle, tempting us as physicians to leave them alone and make them someone else's struggle. But that's the easy way out.

In fact, it is incumbent upon all of us to pick an issue, learn about it, discuss it with colleagues, and even participate actively in doing something about it as a means of integrating our personal values with our professional lives. The reason we rarely see physicians speaking out for social concerns is perhaps because we are afraid to make the time for such concerns—but we must. Your patients, your families and your friends are getting involved in social causes, why shouldn't you? "Because I'm too busy being a doctor" is simply not an acceptable answer.

Although the four areas I have discussed seem fairly different, there is a common thread that weaves throughout the developmental modalities we have discussed, and that is advocacy—advocacy that starts with the realization that something needs to be changed. Whether you decide to speak out for improving conditions contributing to fatigue during your residency, or for instituting programs to reduce stress, or for developing workshops for better communication and teaching skills, or for representing a social cause, you must speak out. No one is going to do it for you, and more importantly, if you don't, your enjoyment of the exciting career ahead of you will most assuredly suffer.

In honor of Arthur Ashe, also speaking this afternoon, let me close by reminding you that medicine is like the game of tennis. Both require you to engage in a "match," and once that happens, both will "serve" you up a

challenge and subsequently "net" you an experience you will never forget.

And, like world champion tennis players, or any other outstanding athletes for that matter, there are developmental milestones to be conquered before they can become professionals. Whether it's learning to master the gross motor requirements of handling the endurance aspect of your careers, the fine motor coordination of balancing your professional and personal lives, the language skills that allow you to be respected and understood by those you work with and care for, or the social concerns that allow you to worry about your fellow players as well as your fans, these are the qualities that you should strive for as you try to master the ultimate game, set and match, otherwise known as your career in medicine.

I see that your delivery this afternoon is almost complete and that your birth certificates (otherwise known as your diplomas) are about to be awarded. Let me close by thanking you again for the honor of allowing me to speak with you today, and let me extend my own personal congratulations to this milestone of a class—the Harvard Medical School Class of 1992!

Lewis R. First '80 is an assistant professor of pediatrics at HMS, and at Children's Hospital in Boston, an associate in medicine, and director of medical education and of the Pediatric Group Association (a resident and faculty group practice program).

What Matters Most

by Joseph Rhatigan

MEDICAL SCHOOL IS KIND OF LIKE A treasure hunt. When you first came here, it was as if you were shown a path that led to a vast canyon, told that countless riches lay hidden among its rocks and crags, and then given a list of things to collect. But you quickly noticed that the canyon was very steep, the path was poorly marked, and the list was written in Navajo. When you had second thoughts about going on, you were told that you would have to pay back your loans anyway. So you slowly learned how to crawl down ravines, how to find your way among the rocks, and how to read Navajo. And you filled your bags with treasure. You stuffed them, in fact, and you never felt like you had enough because there was always so much more glittering around you.

At times you suspected your sack had a hole in it, because the jewel you had just picked up looked exactly like one you had found miles ago, and when you fished around in your sack, you could no longer find it. But now, as you walk back into town with the canyon at your back, you feel on top of the world. As your family and friends gather around you and welcome you back, some of them ask, "What was it you found out there among the dust and the rocks? What exactly did you learn out there in the desert sun?"

Those questions are hard to answer. But you have a bag of booty on your back, and so you pour some of it out on the ground. As everyone marvels over the things you've collected, the thousands of facts you've learned and the numerous procedures you've taken part in, you look back at that canyon and think that there were other things you discovered out there, things that weren't on that list. Some things that matter more to you now than all the treasure you have collected.

When you try to explain some of those things, like how the climb made your step surer and your heart stronger, or how the sunlight set the rocks afire at dawn, you realize how intangible all that looks next to the pile of riches everyone is marveling over. Those things about your step and your heart are not as shiny as the jewels or impressive as the facts you've gathered. The story about the sunlight doesn't leave mouths agape like the tale you tell about the gold you mined or the first baby you delivered.

But I want to talk about some of those intangible things anyway. There are many of them, but I'm picking three: how we learned to handle our fears, how we learned to deal with pain and suffering, and how we learned what it means to be a doctor.

If you stroll down the corridor of your memory, it is not too difficult to find there a room that contains the tattered furniture of things that once frightened us so. That furniture houses all of our worn-out fears from medical school. If you walk inside and sit on the sofa, you will soon feel the numerous anxiety attacks you had during the Human Body block. Shift your weight on it a little and experience the dread that weighed upon you when you studied for the boards. Lay down on the sofa for a second and remember the nauseous dry mouth you would get in ICM when you first started examining

patients by yourself. Once upon a time, that sofa gave you nightmares; today you can lie on it and feel a little nostalgic.

Now try that armchair over in the corner; it's a little less threadbare. Sit back in it and remember how well you slept the night before a new rotation started. Put your feet up and recall all the times you felt like a fool for coming to medical school because you weren't even sure anymore that you wanted to be a doctor. Lay your head back and remember all the times it hung down because you didn't feel smart enough, assertive enough, or strong enough to make it here today.

Although that chair isn't as comfortable as the sofa, you can still sit there and comfort yourself with the thought that you did make it. Only, don't walk over to that closet against the far wall. The furniture in there is new. If you open that door, you will feel a breeze exactly like the breeze blowing today, a breeze tinged with the odor of the on-call rooms that wait just down the hall.

But forget about the closet. I want to know more about the furniture. What enabled us to now feel so comfortable on that sofa? Time and experience, of course, but when we first had to sit there and feel those fears, what kept us from jumping up and running out of the room? Sure we were told we had to sit there, but no one held a gun to our heads.

I think that what kept us there, despite the fear rising in our throats and that knot inside our bellies, was that somehow we learned something: we learned to be brave, which is something our professors never told us to be, something we never consider ourselves as being, but something we had to be.

There were times when we felt overwhelmed and alone, and found shame and failure not looming behind us and goading us on as they usually do, but rather waiting ahead of us and blocking our progress. At those moments, what kept us moving, despite the waves of panic that lapped over us, was not something as grand and rare as heroism, nor were we simply running like cowards away from humiliation. The thing that moved our feet forward at those moments was bravery, simple and unadorned. And as you know, those fears never disappear, that closet is never emptied. Someone is always filling it with new furniture like desks or loveseats. But neither is bravery a lesson soon forgotten.

After we had calmed our fears enough to look beyond them to the patients we were taking care of, the pain and the suffering we saw there seemed, and still seems, unrelenting. Anyone who watches the evening news or picks up a newspaper knows that life is fragile and often punctuated by catastrophes, but that knowledge is abstract and impersonal. Our minds are so numbed by the unending stream of tragedies we hear about that even if they occur in our own neighborhoods, we somehow feel that they could never happen to us. Yet when you talk to patients, even though you can still tell yourself that you are young and healthy and eat all the right food, you are forced to understand that disease and illness can strike suddenly, indiscriminately, and without mercy.

I remember the moment we were first sent to see patients in ICM. Walking around the wards, I felt like a traveller who enters a foreign city, only to find that it has just been pillaged. It was with a sense of wonder at the richness of the lives of the patients with whom I talked, and a deep sense of bewilderment at how horribly those lives could be damaged.

Often the stories were so horrible you just couldn't let yourself feel anything. Like when you talked to the mother of four who had ovarian cancer, and she began to cry, but you just clamped down on your tear ducts and then tried to keep your arm from shaking when you felt her abdomen. After you left the room, you were fine. You just wrote your note and went down to dinner, only you noticed you weren't hungry anymore and you wouldn't be for a few days.

But oftentimes it caught you unaware, like that young man who came in with ulcerative colitis, who would talk to you every morning about the news or the latest book he had been reading. When your surgeon told him he needed a colectomy and an ileostomy, he didn't understand and became quiet and lost as the surgeon explained. Then when he looked at you and asked in a voice as empty as your chest had become, "You mean I'll have to wear the bag for the rest of my life?", you had to excuse yourself and run to the bathroom, stare in the mirror and tell those things running down your cheeks to stop.

If the diseases didn't get to you, the pain and the injustice that people live with every day, the abuse, the poverty and the homelessness did. There were times when you wanted to scream and take an ax to all that is hateful in this world. And when you couldn't, you just wanted something to make it go away for awhile.

From the moment we first sliced through the leathery skin of our cadavers, we tried to distance ourselves from what we were doing. But we learned that we could not and did not want to maintain that distance always. Instead we learned that we had to find some balance, a balance between the sadness we felt with our patients and the distance we needed.

All the while we did this, we tried so hard not to notice our losses, our needs and the petty, base things we would occasionally feel toward our patients: the anger, the revulsion, even the rage, which we so seldom admitted to ourselves. And if we did acknowledge those things as our own, we often felt guilty and shameful about them afterwards. But we learned that we had to feel all those things. They were part of that something that makes us men and women and not machines. And the balance between those conflicting emotions and the distance we needed to simply survive, is something we are

still learning even now. It is something we will relearn again and again.

Having to strike that balance is part of being a doctor, and that is the final thing I want to talk about: how we learned what it means to be a doctor. Although some of our parents or relatives are physicians, although some of us may have worked in ambulances, labs or hospitals before medical school, I think all of us found that becoming a doctor was a little different than what we had expected. We probably all expected the long hours and the overwhelming amount of information we had to master, but I don't think we could fully appreciate the amount of uncertainty and doubt, the physical and emotional demands, and the surprising degree of intimacy our patients gave us, until we experienced these things first hand.

Somewhere between the time we first put on our lab coats for anatomy and the day we finished our subinternships, something about us changed. Nothing major, it's just that I think we see the world a little differently now than when we first came here. Our vision may not be sharper or more perceptive, but somehow it is different, and I don't think we can ever see things as we once did. It's not just the pages of facts we now carry around in our heads, it has more to do with some of the other things that we learned here, some of the things that I've been talking about.

Now, don't misunderstand me. I'm not saying that we've somehow lost our innocence, become cynical, or wiped out all of the mystery in our lives. I'm just saying that we've learned something here, something about ourselves and something about life—a knowledge that is partially wonderful and partially terrible—that has made us more like the physicians who teach us than the patients we take care of. That undefinable thing that I'm trying to describe is part of why our patients come to us. They come not only because of all the facts and procedures we have learned, they also come because they need someone who has seen other people suffer and who understands what that means, someone who they can speak to with honesty, who they hope will tell them the truth because everything else in their lives has suddenly become so uncertain.

Long after we have forgotten how to calculate the fractional excretion of sodium, let us at least try to remember some of the other things we learned here. Don't forget what it was like to be afraid and to be brave; your patients will be both. Remind yourself of the suffering that you have seen because its tragedy and injustice is part of what brought you here in the first place. And remember that as a physician, although what you do may not be the most noble or exalted thing in the world, it is something special.

As a doctor, you are a witness for all of the sick and afflicted who seek out your services. You share in some of the most extreme moments of your patients' lives, and your presence attests to their sickness and validates their suffering. It shows them that their illness is part of life and not something outside and against it.

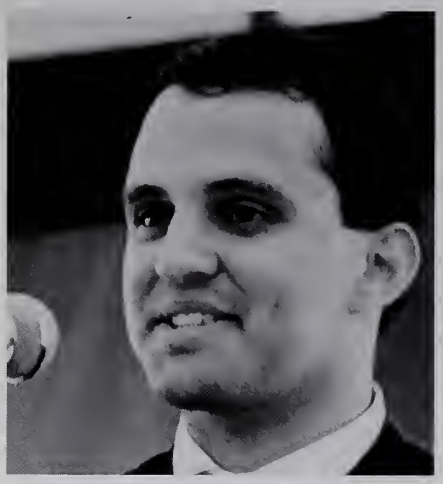
At those moments, your compassion does something that all the medicine and miracle cures you dispense can never do. It reminds your patients that although their disease may have robbed them of many things, it has not yet robbed them of the things that bind you and them together: the many frail, the many impalpable, the many beautiful things that make them and you human.

Joseph Rhatigan '92 is a resident in medicine at Brigham and Women's Hospital. He was also the 1989 winner of the HMS Alumni Association's essay contest.

Jeff Guy '94 and Anushua Sinha '92

The Metamorphosis

by Marc J. Laufgraben



WHEN I WAS YOUNGER, MY ROLE model was Leonardo da Vinci. I even wrote an essay about him for a college application, a sort of "My Dinner with Leonardo." At the time I thought there was nothing unusual in believing that the man who painted the Mona Lisa actually had a lot in common with a 17-year-old New Jersey kid whose greatest accomplishment to date lay in amassing an extensive library of comic books. Yet believe this I did, and soon found myself telling people that my goal was to become "a Renaissance man in my spare time."

Well, my life is different now. Having completed four years at Harvard Medical School, I've come to the realization that all I really want to do in my spare time is sleep. And instead of thinking about old Leonardo, I find myself admiring the man who wandered into the forest one day and took a nap that lasted 20 years. I mean, so what if Rip van Winkle was a little out of touch? As I look around me today, I can assure you that being out of touch has never been a hindrance to a successful career in medicine.

But perhaps Rip Van Winkle doesn't really appeal to you, and you find yourself asking, "Okay, so this is the New Pathway. But as I stroll along, isn't there someone whom I can look up to? Is there a role model here that's right for me?"

My friend Susan says that when she's in a difficult situation, she thinks, "What would Jean-Luc Picard do?" Which is fine: to have as a role model a 24th-century starship captain is at least as realistic as emulating Oliver Wendell Holmes, or even Judah Folkman.

But shouldn't there be a few persons down here, on this planet, in this century, that a young doctor-to-be can look up to? The interns and residents, though generally a hardy bunch, are a bit too much under the thumb of the system to be idealized, so we look beyond them, to the attendings. Having worked with so many of these great doctors, I have constructed a composite whom I shall call... "Dr. Bo."

Bo knows cardiology.

Bo knows hematology.

Bo knows. . .well, Bo knows everything. You, on the other hand, know nothing. Worse yet, Bo knows you know nothing.

So you and Bo reach what is commonly called a "quiet understanding." I was once inspired by this to write a poem. It went:

A quiet understanding we did reach:
I understand so little I could not speak.

Now we have all reached similar understandings with the myriad "Dr. Bo"s that we've encountered. In the end, I think, it is best to maintain a fierce pride in your ignorance, for if it is true that the more you know, the more you realize you don't know, then by some perverse logic, not knowing very much surely means you must be doing quite all right after all.

A few weeks ago, I found myself in the Office of Student Affairs trying to ascertain what responsibilities I needed to fulfill prior to receiving my degree. "Dr. Hundert," I asked, "is there anything I need to do before graduating from medical school?"

"Well, Marc," he said, "why don't you try and learn some medicine?"

Of course, I was shocked for a moment; and then I realized that he was joking. Obviously no one really expected me to learn any medicine before graduating.

But perhaps now is not the best time to dwell on our vast collective ignorance, as I'm sure we will have ample reminders of this in the coming year. Let me reflect for now on the incredible change occurring in our lives today. Although we did not, as Gregor Samsa did, awaken this morning in our beds to find ourselves transformed into "monstrous vermin," today nonetheless marks an extraordinary metamorphosis—no less remarkable than the one in Kafka's story, especially to those of you who knew us when our only means of communication was drooling. Besides, we should be respectful of our fellow graduates, and reserve terms like "monstrous vermin" for those receiving their law degrees today.

I have seen the future of medicine my friends, and we are it.

Now this thought may shock some of you, and I can imagine many of my classmates asking themselves, "Is it too late to get my $100,000 back?" Rest assured that this is a common question, and it is being asked today by thousands of loan officers across the country.

But I urge you not to be too alarmed by the events of the day, and will remind you that we have received our training during a time of great change in medicine, especially here at HMS, where it often seems that, truly, the more things change, the more they stay the same.

Let's take a look at a few examples. For instance, the parking situation. There was always a problem with parking for students (and for that matter everyone else) here at HMS. So a brand-new high-tech parking facility was constructed. It's right below your feet, beneath the Quadrangle. At least that's what they tell me; the last time I tried to get down there they unleashed the hounds. So, you see, the administration has ingeniously solved the problem of student parking: no parking, no problem.

Or how about all the changes in the registrar's office? They've just installed a new computer system, so now they have the capability to make our lives miserable with a greater efficiency than anyone could have dreamed possible. And with the new "bundle system" for handling scheduling requests, they can stick it to everyone at the same time.

And finally there are all those wonderful Macintosh computers at the MEC, stocked full of state-of-the-art educational programs, such as Shanghai and Tetras. Only in the New Pathway would a medical education center be utilized primarily as a video arcade.

Nevertheless, we are here today having successfully crossed the med school minefield, to celebrate our achievement, but also to dream of the future. And so, as I near the conclusion of this address, I am obligated by Section 24 of the official Harvard bylaws pertaining to commencement addresses to say something pithy and uplifting.

I went to what the medical community calls "the literature"—though, as my friends can attest, when I quote from "the literature" it's generally not *JAMA* or the Journal from which I speak. No, in this case I went back to Kafka who, though a lawyer, redeemed himself in other pursuits. At first, thinking of the residency looming ahead of me, I was tempted to quote a line from "In the Penal Colony," but finally I decided on something from the story called "A Country Doctor."

In "A Country Doctor," Kafka explains, "To write prescriptions is easy, but to come to an understanding with people is hard." This "hard" thing, this "understanding with people" which Kafka writes of, is what I think HMS has tried to teach us to consider as we take on our responsibilities as physicians.

I'm not sure how Kafka came up with this without the benefit of years of patient/doctor courses, but somehow he did, which gives me hope that despite whatever obstacles I encounter in my career, I may one day awaken to find myself transformed in my bed into the sort of doctor that I have always hoped to become. Either that or a starship captain. On today, of all days, I wouldn't want to limit the possibilities.

Marc J. Laufgraben '92 is now a resident in internal medicine at Brigham and Women's Hospital.

Dan Murray and Steve Epstein.

Alumni Day

Poetry and contemplation, hard questions and thoughtful commentaries marked Alumni Day this year. Outside there may have been clouds and chilly breezes, but inside the tent was packed with perhaps the largest turnout of alumni and friends ever, who brought with them good humor and the warmth of fellowship. All came, too, with the common bond that would be explored in the symposium that day—participation in the doctor/patient relationship.

The morning opened with the annual business meeting. William V. McDermott '42, director of alumni relations, welcomed over 500 alumni and their families. He specially welcomed Donald Gordon '22, one of the oldest living alumni, who had enjoyed a 60-year career as a medical missionary in Brazil, only recently returning to the United States. "You epitomize the practicing physician we are celebrating here today," McDermott told Gordon, who rose to a standing ovation.

Joseph E. Murray '43B, who will be stepping down after nine years as chair of the Alumni Fund, expressed "tremendous gratitude for the friendships I have had since I first stepped into Vanderbilt Hall in 1940." [See story in "Pulse."] He acknowledged the hundreds of heroes among the alumni who had made his job successful and gratifying. Doris Rubin Bennett '49 will succeed him as chair of the annual fund, continuing the tradition set by Thomas Lanman '16, Langdon Parsons '27, Carl Walter '32 and Murray.

Richard Schulman '67 then took the stage to present the 25-year reunion gift—a pledge from his class for over $200,000—by far the largest reunion gift ever. "I can't think of a happier moment for a dean," said Dean Tosteson '48 in accepting the gift. It was a hard act to follow, but Oglesby Paul '42 came up to present the 50-year reunion gift. He first applauded the 25-year reunion class's approach to getting pledges, but pointed out that the average age of his classmates is 75. "As has been said, 'A bird in the hand is worth two in the bush'," he said, handing a check for $90,000 to the dean.

Special tribute was paid to the late Carl Walter '32, whose dedication and contributions to the school are peerless. Murray called Walter a "constant source of advice and council." Walter was a leader in a remarkable class—including also Bud Stillman and Fred Ilfeld—which through the decades has donated $20 million to the school.

Daniel D. Federman '53, dean for medical education, moderated the day's symposium on "The Doctor/Patient Relationship," calling the doctor/patient relationship "the most extraordinary social contract in human history." He pointed out that there is no parallel in human behavior to the physical access that a physician has to a patient, who confides more about him/herself than even one would to a best friend. In any other setting, such physical access would be legally criminal, he ventured.

Known as the poet laureate of his class, George Bascom '52 left no doubt that he deserved the distinction. Through stories and poems, he moved the audience first to laughter then tears. He spoke in an easy, unrushed manner with a voice that could easily represent the Manhattan, Kansas version of "Prairie Home Companion." Bascom said that he felt like a "deer caught in headlights, who will soon get back to the dark of the forest where the practicing physician usually resides."

Poetry provided the means to communicate the pain, isolation and eventual glory and commitment to life that Lesley B. Heafitz '65 felt during her year-long battle with metastatic cancer, now in remission. From her vantage as the physician who becomes a patient, Heafitz talked of how she learned not only what her patients must feel as they move through their illness and treatment, but also how vital the doctor/patient relationship is in determining the outcome of one's illness.

Keeping with the popular concept instated last year of audience participation, queues of alumni, and a few alumni spouses, commented on the ideal versus the reality of the doctor/patient relationship. Several wondered whether empathy could be taught, or if it must be a quality that one is born with. Jim Bernstein '52 asked what HMS was doing to meet this challenge of teaching empathy, and if medical schools in general could be more responsive to selecting applicants with these qualities. Heafitz responded that empathy is inborn in some people, for others learned from the best teachers or like her, learned by being a patient, but that she has also seen colleagues who lacked such qualities develop them over the years. She suggested that professors guide students who seem to be particularly insensitive into research and other areas that don't require patient care.

A 15-minute break provided enough time for many to find steaming cups of coffee inside Building A, as the temperature dropped quickly. But no one seemed to feel the cold. People were so caught up in conversation, it took five minutes of blinking the lights to get everyone back outside to resume the program. It was quite easy to get carried away with sentiment; the foundation of an institution is its people and those coming home to Harvard are the people.

Thomas Gutheil '67 began the second half of the program and discussed how fostering the doctor/patient relationship is also key to sound risk management. Patients often seek magic, which is bound to lead to disappointment. Sharing the uncertainty of medical outcomes with patients and learning how to apologize are the ways he recommends for avoiding problems in the doctor/patient relationship.

Elizabeth Howell '93 offered a student's perspective on learning the patient/doctor relationship through the Patient/Doctor course. She described how she began medical school wanting to learn the "real" medicine of anatomy and histology.

and felt that the Patient/Doctor course only got in the way of more important matters. But by the middle of her third year, she became overwhelmed with the pain and suffering she saw on the wards, and found great support in Patient/Doctor.

Again, alumni offered their perspectives. Richard Reiling '67 displayed the frustration of a physician who strives for the ideal doctor/patient relationship, but comes up against the facts of reality. Although he would like to spend more time with patients, Medicare only pays him $22 an hour. How can he take enough time, and yet remain solvent? "I'm not asking to drive a Mercedes," he said. "I want to live a practical life as a physician."

Gutheil responded that he thinks of time as a financial investment and suggested that physicians need to make wiser decisions with the time they have: "Where we decide to invest, we have control over."

Dean Daniel C. Tosteson '48 quoted "My Fair Lady" as he gazed out at the audience: "I've grown accustomed to your look." He thanked Joseph Murray and the many who had contributed over the years, especially Carl Walter.

Dean Tosteson noted some of the developments at the school in the past year: the Class of 1992 was the second class to follow the New Pathway through all four years. There are 400 candidates in the PHD program, he said, and 148 of them are MD/PHDs. Forty-three new full professors have been added to the faculty, bringing the total to 340 full professors. An interdepartmental division on addiction, looking at cellular and molecular manifestations of the disease, as well as its social impact, will commence this year.

The dean also expressed how pleased he was with the results of the Campaign for the Third Century of Harvard Medicine. "I hope that this reunion has strengthened your part in the family of HMS, a family that goes back 200 years," he said, "Everyone in this room is a steward of that tradition."

Will Cochran '52, associate clinical professor of pediatrics and the new president of the Alumni Council, presented a gift to outgoing president George Bernier '60, who is dean of the University of Pittsburgh School of Medicine. It was a clock, "because he has given so much time to the school, in hopes he'll now have more time."

Unprecedented gesture

Class reunion gifts to the school have always been a nice gesture. But the Class of 1967 has raised this tradition to a new summit with a 25-year reunion gift of over $200,000 pledged—almost double the largest gift ever.

What prompted this outpouring? Here is a class who 10 years ago, on the pages of the Bulletin, explored the stresses they had experienced at medical school and in their early careers—a class with members critical of the educational experience they had had at HMS.

"I can tell you what moved me," answered Richard S. Shulman, who has been class agent since graduation and was co-chair of his class reunion with Philip L. Goldsmith. "It's very straightforward. I love Harvard Medical School. A few of us got together and decided to do something special—because Harvard is special and we are special."

Reunion committee members decided to combine reunion organization with a fundraising effort, and then tirelessly called everyone in their class. The result was the domino effect: once a few gave, over half the class gave.

Shulman says that the theme of the reunion, which focused on the doctor/patient relationship, also impressed on his classmates what had changed at HMS. "Many remembered a school with a cold, indifferent attitude toward students. But now, clearly this has become an institution more involved in preparing students for day-to-day doctoring."

The Alumni Day program on the doctor/patient relationship, moderated by Dan Federman '53, included Class of 1967's Tom Gutheil. And other classmates addressed related themes in symposia on Thursday of reunion week: sessions with such titles as "In 1967 a Handful, In 1992 a Crowd—Women in Medicine," "On Being a Doctor: A 25-year Retrospective—Did We End Up Where We Aimed?" and "How Will Physicians Fit Into the Current Scientific Revolution?"

"At reunion, people were really excited about the sense of community," says Shulman. "They were pledging money up to the last day." Shulman hopes that their gift will set a precedent for other reunioning classes. Perpetuating the spirit of the reunion theme, he says his class plans to specify that their pledged gift be used for programs focusing on the doctor/patient relationship.

Ellen Barlow

The Doctor Who Was There

by George S. Bascom

IN MY FATHER I HAD A REMARKABLE example of a faithful doctor. He was a good and generous man, an anatomist, surgeon, obstetrician and family doctor. He loved the practice of medicine, enjoyed his patients and their stories, made housecalls in town and out into the country, climbed out of bed many a night—once, so tired he made a wrong turn and lost himself in the clothes closet.

He did kindly things for patients, some that I am still hearing about for the first time, now almost 20 years since he died. He got a great kick out of practicing medicine. Oh, sometimes he lost his temper. Parents who procrastinated all day about a sick child and then called at bedtime at times provoked him into hanging up with a force that nearly took the phone off the wall. But he couldn't sustain it. Face to face with a patient, anger melted away and he was himself again, kindly and concerned. Of course, Franklin D. Roosevelt never asked for a midnight housecall. That would have been the supreme challenge.

My three brothers and I learned to drive by chauffeuring my father on housecalls, and we all followed him into medicine. I gave research a fairly honest try—though, I now confess to reading Jonathan Swift's account of the plague of London with more interest than Homer Smith on the kidney. Oliver Cope was kind and tolerant. It was a splendid year, a great opportunity. But late one winter afternoon, standing in pale sunlight before a Fisk osmometer and racks of frozen dog urine, I understood in my heart of hearts that I was a practitioner.

So we went back to Manhattan, Kansas to practice general surgery, an ambiguous, ill-defined practice of broad scope, which I found enchanting. I say "we" went back to practice because it is a family affair. Let me here offer heartfelt and humble thanks to my spouse and children for their unselfishness, patience and unrecognized sacrifice. They are the true unsung heroes, and sometimes the uncelebrated victims.

I offer a few scattered observations out of this background on what I believe I owe my patients, on what it sometimes costs, and on what I find makes it all worthwhile.

I owe it to each patient to be fully present and to be competent. Easy to say, but hard to maintain in the face of fatigue, a heavy patient load, the family waiting supper, and a ringing telephone. Haste and distraction make it easy to stop listening. Only a lively relationship with the person I am caring for—that "thou" of whom Martin Buber speaks—can hold me to the effort. We have committees and reviewers now to watch over us, but in some ways they remind me of a solemn liberal congregation in my hometown.

A Liberal Congregation

The unpersuaded fellowship,
sober with the task of disbelief,
finds it needful somehow
to gather every Sunday
to insist on the absurdity of God
and the importance of a book review.

You see, they have progressed beyond a belief in the Almighty and are busy reconstructing the universe on their own terms.

Besides knowing my business and paying attention to the patient, I owe an affectionate commitment to his or her welfare, a fidelity that sees people through, stays with a family and a patient the full course through complications and trouble, not running to cover or drifting off when the going gets tough. Affection is priceless in a doctor. Don't ask me where it comes from or how to teach it. It certainly can't be enforced. Maybe it comes from being loved. Maybe it is encoded in the genes. But doctors who like their patients provide something HCFA has not codified, something that transcends the legal contract. It may not hasten wound healing, but it makes the hurting more fun.

You are all familiar with the costs of affectionate fidelity. Time, for one thing, time that could be spent with family or recreation or study or rest. In a life of limited hours and boundless, ever-renewing calls for help, the practitioner is always slighting someone.

Time is limited and so is power. Sometimes we are helpless. That is another source of pain. Anna was a six-year-old girl who died of a neurolemmosarcoma at the base of her skull. She suffered a lot from her tumor and harsh chemotherapy. Anna never spoke to me when I visited her at

home, leaving that to her mother and father. On one occasion not long before she died, our eyes met and held in silence.

Anna

Her luminous dark eyes
held mine in something silent.
Her mother's kitchen noise
came from a different world.
We were that moment
quite alone with utter mystery.
From her small bed
Anna's eyes saw through
the camouflage of age and learning,
encountered me on my death chair,
stared through me at the depths
from which her suffering arose.
And the infinitude defying reason,
the reality which offers nothing but itself,
the uncertainty that is the answer
looked back at her dark eyes
from somewhere far beyond my tears and helplessness.

Error hurts, too. Mistakes in technique or diagnosis are inevitable, but agonizing. Plaintiff attorneys are merciless, but our own peer review system is pretty tough, too. It often deepens my mortification and grief without teaching my colleagues anything they don't already know. I wonder if the process doesn't need to include positive reinforcement, some leavening of criticism with commendation. We need forgiveness, a need unmet by the clinical dissection of a tragedy.

I was once forgiven by a patient and family for a clamp left in the abdomen. That act sent a wave of gratitude through me and enriched my spirit. There is some reciprocality in this business of caring for the sick. And the physician is not always the healer.

Worse than pain and embarrassment and guilt may be a dehumanizing numbness. This middle-aged nurse left five children when she died of breast cancer.

A Gift of Tears

I did my job.
Looking back, reviewing all,
I wouldn't change too much.
Oh, I would have stopped by oftener, I guess,
to answer questions for the kids—
maybe put to rest some fears about—oh,
contagion or
the dark uncertain working out of death.
We did
control her pain and after several days
at last subdued the awful nausea. I
held her hand one night, and
while she wept, managed not
to say a lot of damn fool things.
I pronounced her when she died,
said what I should
and then drove home.

At the funeral, impatient and annoyed,
I found the parking lot was full,
the church packed to the rafters.
Surprised so many knew her,
surprised so many cared,
high in the balcony I found a seat.
I mused and drowsed through hymn and prayer
while far below from time to time
one of her girls broke into sobs
that ricocheted from cross to organ pipes.
Halfway through the eulogy
between the salvos of her grief,
politely open-eyed, respectably erect,
I felt a sudden sting.
My eyes filled without warning
and as I blinked against the tears,
I thought, "Thank God!"

Well, why do practitioners expose themselves to a grief that is sometimes numbing? Because there is almost always some real help to offer. Most of what we do works and patients get well. It can lead to a euphoria close to hubris.

Hubris

For a moment I understood
Why He is so chary with success.
It is a heady drink.
Last night I did
A ruptured aneurysm.
Every move was right—Well, not every move.
I tore a vein—
But every vital move was right.
God dealt kindly with my errors,

And the man emerged from anesthesia
Like spring arriving on the plains.
Of course, I knew who pulled my patient through
(at least I knew who didn't).
Yet driving home I caught myself
Expecting stoplights
To turn green as I approached.

That is only part of it, though. And money is only part of it. The best part is trust met with trustworthiness. Friendship arises out of the ordeal the patient and I pass through together. We have each been vulnerable, we have survived, and life is good.

On our better days, we practitioners may embody and propagate an ancient value, caritas, charitable love. Against a value system that elevates productivity, sales and income after taxes, the caring physician can bear witness to a better one in his relationship to the patient, one of affection. In that order of values, each of us is measured not by income or prestige, but by the affection and the fidelity with which we commit ourselves to the person waiting behind the door of the next examining room.

I will close with a conversation between two Iowa practitioners that I overheard four years ago. Take it as my salute to all those good men and women, those good doctors out there at work today.

Being There

Unhurried, easy in his chair, John H. Hemmessey
reflected without heat on changes in the way
we practice medicine today. Hemmessey said
"You expected to take care of people
in the old days. If they couldn't pay,
well, hell, you wrote it off. It was
understood…you charged what you thought
people could pay. I only gave
a bill to a bill collector once. He collected it
and then ran off with all the money."
Hennessey laughed. Across the table
Homer Skinner grinned.
He knew. He'd practiced surgery in Carroll for—
God, about a hundred years! In his forties
it came to him he'd never be a professor, write
important papers, or teach a dozen worried residents.
He felt pretty inconspicuous in Carroll.
But a Lutheran minister's son ruptured his spleen, and
a sharp old doc down south of Carroll
called him in. Homer took out his spleen
and saved his life. Oh, he knew
any surgeon worth his salt could have done it, too. But he was the one who was there,
and he, Homer Skinner, did it, no matter others
could have. That's the point.
They brought him a basket of orchids that Christmas. But
the splenectomy that night was Homer's turning point.
From then on he was satisfied to be the surgeon
who was there.

George S. Bascom '52 is a surgeon in Manhattan, Kansas.

The Empathic Way

by Lesley B. Heafitz

SOME DAY, SOONER OR LATER, EVERY single one of you will become a patient, and I dare say you will not particularly like being on the other side of the bed. However, I know you will find it enlightening, and I am certain that you will discover what a vital role the doctor/patient relationship plays, not only in determining the nature of your experience as a patient, but perhaps also in even shaping the outcome of your illness.

Empathy is the key to a good doctor/patient relationship. Empathy, for the physician, means the ability to experience the illness with the patient, from the inside out, so to speak, feeling and seeing it through the patient's eyes. Empathy is a gift. For some it is inborn, for others it is learned from the best teachers, and for still others it is acquired by actually being a patient. This was my case.

Just about a year ago, I was diagnosed as having metastatic adenocarcinoma of the peritoneum. I emerged from that year, in remission, profoundly changed as a physician. Returning to practice, frustrated by the trends in medical care today, but vowing, nevertheless, not to lose sight of what I'd learned as a patient, I wrote the following poem:

No Place to Heal

I sat at my desk and I knew it was wrong
To stay in a system where I no longer belong.
True healing cannot be done by the clock—
This is not how I measure "standard of care!"
To assess how they're feeling
A bond must be formed;
From caring comes trust
And that all takes time.

These third-party payers cannot understand—
It's business, not healing, they have in mind.
If I stay in this system I cannot survive,
For I want really to heal,
To reach into their souls
And bring out their smiles,
To help them get well
As they help themselves.
This I shall do,
It's G-d's work and mine.
If I cannot do it here,
Then I'll have to leave...
I shall go where there's time
To do what I must,
To share with the patient
In that moment of trust.
I can guide them to heal,
As I've healed myself,
For I now comprehend
What true medicine is.

These concepts are not new. Months after writing this poem, when I was gathering material for this speech, my husband drew to my attention an address entitled "The Care of the Patient," delivered in 1927 to Harvard Medical School students by Professor Francis Weld Peabody, shortly after he was diagnosed with gastric carcinoma. The following are his words, colored I'm sure by his experience as a patient:

"The good physician knows his patient through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

How can we adhere to these principles in the face of the changes we are seeing in medicine today? I think the answer is already forthcoming. Yesterday's *New York Times* (June 4, 1992) carried an article on the front page that told how medical schools are now including training programs in their curricula that teach future physicians what it's like to be a patient through first-hand experience.

Empathy implies understanding the patient's responses to his or her illness, and three responses that I consider most important are anger, fear or anxiety, and hope. It is important that the physician comprehend the full depth and breadth of these responses, and weigh every word and action with this understanding in caring for the patient.

The patient's initial response to disease is often anger. Anger is important because it can so easily be deflected from the disease onto the physician. It was in recognizing my own anger at my illness that I suddenly realized how much anger, misdirected onto the physician, must be food for a lot of the malpractice activity that we bear witness to today.

The patient, facing the unknown, is alone and afraid. To shed some insight on the extent of that fear, I'd like to read the following poem, written not when I was contemplating cancer itself, for I was already in remission, but merely when I was contemplating my final chemotherapy treatment:

Doubts and Cowardice

Tears soak my pillow
They hurt my head.
I want so to go on living
(And not be dead);
But I am caught,
I can't decide
How to best remain alive.
If they pour more poison into me,
I fear I may yet cease to be.
I begin to feel so broken now—
More than my hair has fallen out!
Where is my strength, fight and vigor
Which conquered illness and made me heal?
What is this cowardice I feel?
It was not there before,
When I was fighting for my life
And won.
Will this be death when the war is over,
As by an accident it comes
To the soldier returning home?
Can I rally just one more time
And close this chapter of my life?
Just a chapter—not the end,
Not now, with the book just opened
Once again.

It is the job of the physician to allay the patient's fear with compassion. He or she must never play upon this fear in order to attain compliance with the diagnostic and treatment regimen. Nor, may I add, must the doctor allow his or her fear of the unknown factors in the patient's illness to overly govern that regimen.

Each of us has a survival instinct, and for the patient, the answer to fear is hope. Today, we all know how much a patient's attitude can affect the outcome of his or her illness. The physician, even in the most hopeless circumstance, must remain optimistic—not dishonest, but optimistic. He or she must see the cup as half full, rather than half empty.

To give you an example from my own case, during a check-up at an institution not far from here, I was told by a young physician, "You know, there is a high recurrence rate in your illness, 20 to 30 percent." I never wanted to see that physician again. How much better it would have been if he had said to me, "You know, there is a high cure rate in your illness, 70 to 80 percent."

To maintain a good doctor/patient relationship, the physician must be honest at all times. Without honesty there can be no trust and trust is an essential ingredient of that relationship. Honesty means not only letting the patient know the facts, but also letting him or her know what you do not know.

Honesty also means not making assumptions. Do not assume that the patient, particularly if he or she is a physician, knows the facts about the illness. For all patients, after you have given them the facts you may have to repeat them, for we know how the

anxious patient can misconstrue what he or she hears for the first time. It is better to repeat something than to leave something out. Not making assumptions means you must also not assume what the patient can handle. Unless specifically instructed to do so, do not withhold the truth.

The doctor/patient relationship also involves control. We as physicians have been used to playing God, being in complete control, not only of the illness, but of the patient him- or herself. Is it any wonder that the public today, litigious as it is, is finding fault with us when we fall short of this image of perfection that we ourselves have established in the past?

There is a better way, and that is in shared control—allowing the patient to share in decision-making regarding diagnostic procedures and treatment, and yes, if it's necessary, even in the terminal management of the illness. Different degrees of control are appropriate for different patients, but even the patient who would like to put the physician completely in charge should perhaps be given some little detail to control so that he or she may have a handle on the illness. To draw another example from my own illness, my second-look surgery was scheduled to take place a day after an event in which I particularly wanted to participate. I asked that my surgery be changed so that I would be operated on a week before this event, knowing that this would force me into a speedy recovery. Indeed, this small change had exactly that effect.

No mention of control would be complete without alluding to alternative medicine. I say this for two reasons. Today, when patients are sharing management and decision-making, not only are many turning to alternatives, but medical service too is beginning to realize the validity of some of these alternatives. The second reason for mentioning alternative medicine is that much of it deals with the patient's mental and psychological control over illness, and we in medicine are realizing how important control is in determining the outcome of the illness.

Photo by Barbara Steiner

Harvard Medical School has recently established the Mind/Body Institute Chair in Behavioral Medicine. Wellness communities for cancer patients are being set up where, as their literature says, "Alongside psychoneuroimmunology...a new psychosocial concept that involves cancer patients in the fight for their recovery" is implemented.

As a physician, I am fully aware that radical surgery and chemotherapy brought about the remission that I am currently enjoying. But I also know that my positive state of mind and the work I did with meditation and guided visualization did a lot to help affect my recovery. To illustrate this, I would like to read another poem:

Invincible

I am invincible!
My heart, my soul tell me so.
No matter what is done to me
I am in control.
I am the master
Of my physical whole.
There is a guiding energy,
A magic light, a flame within.
No one can quell it
For it's mine!
It gives me strength; it gives me life.
With its help
I'll win this fight.
I know now no more fear.
From that fire that burns in me,
I will heal.
I shall beat this disease
Once and for all.

Compare this, if you will, with the other poem about my fears, written only days before. I truly believe that the medicine of the future will be a blend of traditional and alternative medicine, working side by side to achieve not only the physical, but the psychological and spiritual holistic healing of the patient. Until that time, do not dismiss the alternatives that the patient is choosing, or they will become just that, complete alterna-

tives. Rather, allow patients to use these as adjuncts to what you have to offer from traditional medicine.

To summarize, a good doctor/patient relationship is based upon empathy, and empathy implies understanding the patient's responses to his or her illness, key among these being anger, fear or anxiety, and hope. A good doctor/patient relationship must maintain honesty at all times. Finally, a doctor/patient relationship should not be one of exclusive control by the physician, but rather shared control by patient and physician working together to achieve the optimal outcome.

I would like to close with a poem that I think summarizes everything I have said:

Patient's Plea, or To My Physician

Dearest physician,
I trust myself to thee.
Please be careful
How you handle me.
Handle me with care and love;
Give me time to comprehend
What you with training understand.
Do not shield me from the truth,
Rather try to feel, yourself,
The weight its meaning brings to bear
Upon my mind and heart.
And if your words will sting my soul,
Bestow them gently
And choose them carefully.
Do not steal my dignity—
Though you steer the ship for me,
Let me put my hand, too, upon the wheel
So that I may feel,
I have control.
Though I'm afraid
And so are you,
Do not control me with that fear.
Let us face together the unknown
In partnership and hope.

Lesley B. Heafitz '65 is in private practice in Newburyport, Massachusetts. She is a visit in the pediatric component of the ambulatory care clerkship and a tutor in the patient/doctor course.

From Healer to Horror

by Thomas G. Gutheil

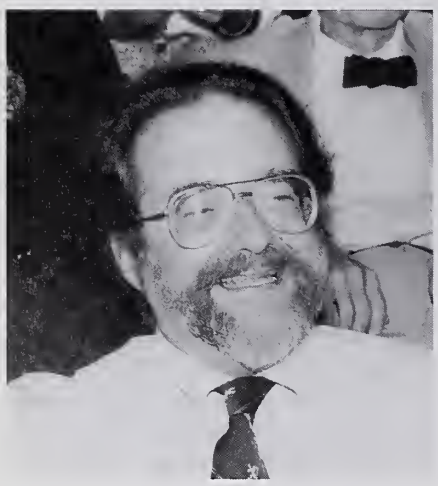


Photo by Barbara Steiner

IT IS ALWAYS A PLEASURE TO ADDRESS a huge audience of health professionals, the majority of whose blood supply, thanks to the break, has just deserted the cerebral cortex in favor of the GI tract. When I was kindly invited by Dean Daniel Federman '53 to give this presentation, he made it very clear to me that the speech should be filled with the wisdom of Hippocrates, the wit of Freud, the clinical savvy of Osler, and the practicality of the Lange paperback series—just as long as it fit into 15 minutes. I suppose that's a bit of that "Dean humor" you hear so much about. Now this time constraint didn't bother me much, since, given how fast I talk, I could probably fit a two-day seminar into that time slot. Not for nothing do the residents and students refer to me as the "bionic tongue."

You may wonder why, in discussing the doctor/patient relationship from the psychiatrist's viewpoint, I would use a title that paraphrases a line from an W.H. Auden poem called "Five Songs" that is really about attempts to discourage the listener. You may also wonder why anyone addressing past and present Harvard medical students would think that that audience had anything left to learn about people trying to discourage them. But the meaning of the title can be understood like this.

You have all met physicians on the wards and in the teaching settings (and if you have not yet, you will) who seem as though they would prefer to be pulled to pieces by teams of wild Caucasian ponies rather than spend any time actually talking to a patient. And there are other physicians who would prefer the pony treatment plus a root canal without anaesthesia to talking for one minute to a patient's family. These physicians appear to have a horror of the interpersonal aspects of the doctor/patient relationship.

This condition reliably leads to job stress, physician impairment, professional burnout and, as I will note shortly, malpractice litigation. Now we must feel some sympathy for these practitioners; they are, after all, usually victims of TND, terminal narcissistic disease. But these physicians often were reasonable healers, at least before medical school. So, from healer to horror.

But what happens to young healers in coming to grips with the relationship with the patient? One thing I do not need to tell this audience is that, doctor/patient-wise, medical school starts you off on the wrong foot. Your first patient is appropriately horizontal but curiously mute, unable to engage

in a dialogue, even after you get the wrappings off. Later, in the clinical experiences, one tends to focus on proper techniques, such as the proper technique of percussing the eyeball or whatever new thing it is that they are teaching now, as opposed to when I went to this school.

Those of you who have groaned under the merciless lash of my supervision while taking the psychiatry clerkship at Mass. Mental already know that for psychiatrists, the relationship itself is our EKG and x-ray, our aspirin and penicillin. But I want to introduce a new twist on this truism: I want to suggest that fostering this relationship is also the secret to sound risk management.

Now I can tell from the dark glances and ominous mutterings in this Harvard audience that I am committing a major rhetorical solecism in that I have been lecturing for several minutes thus far and have not yet quoted the research literature. So let me allude to an article I recently reviewed, which I must summarize a bit broadly and generally, as well as anonymously, in the name of confidentiality.

The study used two videotape clips that I will describe as portraying "Doctor Nice" and "Doctor Mean." Dr. Nice showed "positive communicative behaviors," which meant that he listened to the patient, made eye contact, spoke simply and respectfully, and asked the patient for his own opinions. Dr. Mean demonstrated "negative communicative behaviors," by which he presumably avoided eye contact, taped the patient's mouth shut, spat tobacco juice on the patient's shoes, stole his wallet...well, perhaps that wasn't exactly what was happening, but you get the idea.

These video clips were crossed with different scenarios and problematic medical outcomes, including error, possible negligence and admitted wrongdoing. Subjects rating the videotapes forgave admitted wrongdoing by Dr. Nice and believed Dr. Mean had done wrong, even when he hadn't.

Photo by Barbara Steiner

Nancy Oriol '79 and Cheryl Dorsey '91 at the Coleus Society reception.

But the cream of the jest was that some uninvolved observers happened to catch a screening of the Dr. Mean tape, which had been designed by the researchers, mind you, to be a flaming caricature of bad rapport. These observers made spontaneous remarks, such as "Wow! You've really captured the reality of it!" or "So, it's an examination by a doctor—so what?"

Now it is all very well to talk of the sound doctor/patient relationship and what a dandy thing it is, but the question remains how to turn a somewhat abstract notion into teachable techniques and practices. I have some suggestions based on consulting to the Risk Management Foundation of the Harvard medical institutions. (For those who don't know, these are the insurers who have given us all a pariah complex by secreting themselves offshore in the Cayman Islands, doubtless for some obscene taxual purpose—just kidding, folks, heh heh, keep sending me those cases.)

In consulting to them, I have developed Gutheil's first principle of risk management: "No patient in the history of medicine ever sought out a physician for medical care." Some of you may think you heard that wrong so I will repeat it: "No patient in the history of medicine ever sought out a physician for medical care."

What people seek, as I shouldn't have to tell you, is magic: turning back the aging process, reversing the irreversible, repairing the irreparable, undoing the effects of decades of loose living, and so on. A potential conflict exists when the physician offers "merely" top-level medical care and the patient secretly expects magic. But you can't address the patient's wish for magic directly because to do so would make the patient sound superstitious at best and psychotic at worst.

Even more problematic, the patient has enormous resistance to sharing fears with the doctor; the average patient's central concern about any procedure, no matter how trivial, is: "Will I die?" But to ask that out loud seems to cast aspersions on the doctor's skill or good faith, so patients usually suffer this fear in silence. So what is the physician to do?

My group at Mass. Mental—the Program in Psychiatry and the Law—recommends an approach with two elements. The first element is sharing uncertainty. This is a way of tactfully decreasing magical expectations as a way of improving the relationship so that it can withstand even bad outcomes.

Before describing this, I must digress to an experience I had while giving a risk management lecture at

the Mass. General. After I had reviewed the approach to countering magical expectations of the patients—the approach I will describe shortly—there was a question period and a physician from some specialty or other got up and tried to make the point that here he was at the Mass. General and, by God, as far as the rest of the country was concerned, they were doing magic, right there in those halls. Now that I hear myself, I guess he was probably a surgeon.

I smiled at him and gave him a cheery and encouraging response, "See you in court!" That usually straightens them out. The point is that a magical relationship with a patient can only end in disaster—in the shattered expectations and hurt feelings that are the essence of the psychology of litigation.

What I am recommending instead is a specific manner of communicating. Several examples of what this sounds like will probably be clearer than abstract concepts. These are some representative comments you might make:

"You know, Mr. Jones, I sure wish the Lord in His wisdom had come up with a medication that was completely free of side effects"; or, "Gosh, Mrs. Smith, I certainly wish I had an ironclad guarantee that you would make it okay through this operation"; or "Gee, Mr. Wilson, I sure wish I had some kind of stone tablet here that would ensure that this course of chemotherapy would completely stop your cancer," and so on.

Notice what is being conveyed here: the doctor too wishes for magic; doctor and patient are really on the same side of this issue. But the doctor's rueful subjunctive—"I wish it were so"—gently and tactfully disillusions the patient about the magical model of treatment, and replaces it with shared uncertainty, which doctor and patient now face together and which thus becomes discussible. An alliance built of shared uncertainty can tolerate even a bad outcome.

But suppose there is a bad outcome, what then? The second element of our approach is instruction on how to apologize. That may seem simple enough, but there are more wrong ways to say you are sorry than there are right ones. For example, if you say to the patient, "I sure am sorry I negligently deviated from the standard of care so as to proximately cause you these harms," your insurer might well assert that that was infelicitously phrased, since that, of course, is the technical definition of malpractice.

It is not much better to say, "I sure am sorry that scoundrel Dr. Green botched your case"; or "I sure am sorry that respirator blew up in your face." Rather, the best apology expresses regret for a bad outcome and for the patient's distress: "I am sorry you are in so much pain"; or "I am sorry you are feeling so badly just now."

Understanding the sharing of uncertainty and the way to say you are sorry constitute a clinically-based approach, not only to risk management but to greater comfort, less tension and less opposition in the doctor/patient relationship.

We also thus avoid defensive practice. Defensive practice is perfectly captured by a New Yorker cartoon that shows a doctor reassuring a patient, "We medical practitioners do our very best, Mr. Smith; nothing is more sacred to us than the doctor/plaintiff relationship." We can clearly do better than that. I have tried to suggest how.

Thomas G. Gutheil '67 is professor of psychiatry at HMS and co-director of the Program in Psychiatry and the Law at Mass. Mental Health Center.

The Heart of the Curriculum

by Elizabeth Howell

AFTER THREE TRAUMATIC YEARS IN medical school, one more studying public policy at the Kennedy School of Government, and numerous phone calls home, I have a hard time even getting my mother to listen to my opinion about medical education anymore. Since I have got you all trapped here, I will enjoy taking advantage of this opportunity. I would like to shed some light on a student's perspective of the increasingly complex doctor/patient relationship. Specifically, I would like to give an insider's view of how Harvard Medical School prepares future physicians to face the realities and limitations of their profession.

Over the course of my medical education, my view on the patient/doctor relationship and its inclusion in the

HMS curriculum has evolved. At first, the patient/doctor course was simply a nuisance distracting me from my study of "true medicine": anatomy, histology, biochemistry, physiology. In the patient/doctor course, we discussed the different models of the doctor/patient relationship: active doctor and passive patient versus a "mutual understanding" relationship where both doctor and patient are active participants.

The goal at that stage was to feel comfortable with our patients, to be a good listener, and to develop good interviewing techniques. We reviewed patient interviews with our instructors, who then would ask us how we felt about our patient experiences. My classmates and I weren't exactly sure what we would do with this "touchy/feely" side of HMS education.

Even during third-year clinical rotations, we were pulled away from the clinical wards one afternoon a week. I often felt like I was missing out on important learning on the wards. It seemed like the human side of medicine could only be learned through hands-on experience, and the value of the course was small when compared to the mastery of technical skills.

However, in the middle of my third year, I became overwhelmed with the pain and suffering on the wards. This period I label the overly compassionate phase. With every bed came some huge diagnosis: AIDS, ovarian cancer, lung cancer, breast cancer. Everyone was dying, young and old.

Concurrently, the patient/doctor curriculum began addressing issues of death and dying, chronic illness and medical ethics. We explored patient's coping strategies for illness and tied this to patient compliance with medical regimens. We learned that we had to explore how patients interpret illness.

This was a difficult time for me because I have a tendency to get too close in situations and I don't put up appropriate boundaries. My patient/doctor group provided a forum for discussing these issues, as well as the fear and helplessness I felt in taking care of these patients.

I will always remember my last night on call at the Mass. General Hospital for my medicine clerkship. A 57-year-old woman came to the emergency room with end-stage ovarian cancer. That evening, she was told her diagnosis. I stayed up for hours reading about this horrid disease and the extremely low survival rate.

The next morning I stopped by to chat with her for awhile. She began to ask me all sorts of questions about ovarian cancer and her prognosis. My eyes filled with tears. I felt extremely sad and helpless. I quickly excused myself and then broke down and cried. Life wasn't fair. That entire day, the last day of my core medicine rotation—when I was supposed to be elated that I had survived it—I couldn't stop crying.

Later in the afternoon I returned to her room, sat down and held her hand. I explained as much as I could about her condition. She then told her view of this illness. She still had a tremendous outlook on life and was planning to live the rest of her life to its fullest. She gave me perspective.

I think this was the beginning of the next phase, a never-ending search for balance: the balance of displaying empathy, caring and understanding, with self-reflection, in order to help the patient to the best of our abilities. As healers we must address both the biophysical and the social and cultural context of disease. We have to be willing to listen and to learn from our patients. And we have to be able to accept death.

In his Class Day address yesterday, one of my classmates said that we have learned that illness is not separate, but is actually a part of life. The patient/doctor course has given me perspective and allowed me to become a more effective caregiver. I realize that the expression of human emotion does not need to be overcome, but rather used to make me a better physician.

By establishing a framework for dealing with ethical issues, and involving the student in the doctor/patient relationship debate from the beginning of his or her training, Harvard Medical School uniquely prepares its students to deal with this ever-changing dynamic.

Elizabeth Howell '93 will graduate next year with a medical degree and a master's in public policy from the Kennedy School of Government.

Reunion Reports

60TH

THE 60TH REUNION OF THE HMS Class of '32 was highly successful, although modestly attended. We were deeply saddened by the passing on May 5, 1992 of Carl W. Walter, a shining light of our class. He had become ill in the midst of reunion preparations. Carl, a mightily successful HMS fundraiser, had also been our class agent, reunion chairman, secretary, treasurer, and chief factotum.

Our class has lived through most of the 20th century. Only the late Jack Gibson was born in the 19th (1897). Of the 120 graduates, 34 (28 percent) have survived. We have witnessed two world wars (one in which many of us served), several other conflicts, and the Great Depression. Medicine has evolved from the horse-and-buggy days to high technology, fragmented into a myriad of subspecialties. The specialty boards appeared early in our practice years, and many of us were pioneer diplomats.

In our reunion report, most of those responding deplored the high cost of medical care and education, and the decline of 'caring'.

Our reunion began with a dinner at the Harvard Club of Boston on Thursday evening. Nobel Laureate Joseph E. (Joe) and Mrs. Bobby Murray, Richard J. (Dick) Wolfe of the Countway Library and Mrs. Elin Wolfe, and Susan Finitsis (Carl Walter's secretary) were our guests. On Friday evening we attended the Boston Pops, with dinner in Symphony Hall. Thirteen classmates, ten spouses and one widow came from as far away as California.

There was logic in our choice of guests. Joe Murray, invited to represent the medical school, had related in his 1991 I.S. Ravdin Lecture before the American College of Surgeons how Carl Walter's modification of the hemodialysis machine had facilitated the first kidney transplant. Mark Altschule, honorary curator of the Countway Library, brought him close to our class.

We boasted such outstanding members as Altschule, Harry Beecher, David Cogan, Lester King, Carl Walter, Claude Welch, Augustus Rose and others. Dick Wolfe suggested that our class was possibly the second most distinguished in HMS history, exceeded only by the Class of 1858, with such stars as Reginald Heber Fitz and Henry Pickering Bowditch, a distillate of returning Civil War veterans.

Many members of the class on Thursday attended a stimulating symposium on the New Pathway and, of course, on Friday, Alumni Day. Dean Daniel C. Tosteson '48 singled out the Class of '32 as the largest contributor in HMS history—$20 million over the years, thanks to the efforts of Carl Walter and later Joe Murray, and more especially because of three individuals: Carl Walter, Frederic William (Fred) Ilfeld, and James (Bud) Stillman. The latter two, in the audience, were recognized.

A timely event was the dedication on Wednesday, June 3 of the Carl W. Walter, MD Amphitheatre in the Medical Education Center. An excellent portrait of Carl hangs there.

On Friday afternoon, a poignant and well-attended memorial service for Carl was held in the Memorial Church in Harvard Yard, followed by a reception in the Harvard Faculty Club.

Claude E. Welch, only the third class president in 64 years after Frank B. Cutts and John C. Ham, presided at the events. A clambake planned for Saturday at the Walter estate was cancelled out of respect for Carl. His widow, Margaret, a steadfast and courageous lady, admired by all, cheerfully attended the events.

Two innovations were introduced by our class: the first, the listing in the reunion report of all 120 graduates with dates of birth and, if applicable, death; the other was a dinner program giving recognition to Robert M. (Bobby) Green '06, who taught us anatomy in brilliant lectures of classical beauty and to whom our *Aesculapiad* had been dedicated. In gracious acknowledgment, Bobby said: "May I return your compliment by dedicating to you these verses with most cordial gratitude and affection?"

My Library

My library's a cellar of old wine,
Each book a bottle, filled with vintage rare,
And exquisite bouquet of the divine
And blushful Hippocrene. And whensoe'er
I will, I bid my Thalicarchus bring

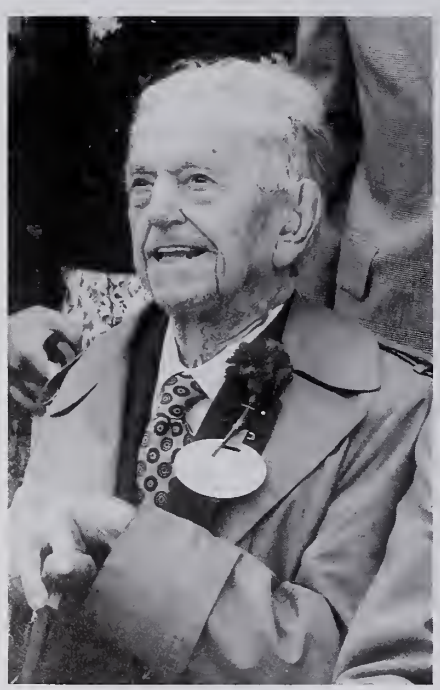
Left:
James Sacchetti '27

Reunion photos by
Richard Wood

The flagon of my choice, and fathoms deep
I drink libation of the Pierian spring,
Where still the bards of mirth and passion keep
Immortal quintessence distilled. Nor e'er
Those flasks shall fail of their
Falernian brew,
Exhaustless as Philemon's draught; for there
The Olympian liquor doth itself renew;
And like a sacrament reserved, they dure
Forever blest, forever full and pure.

Heretofore, formal HMS reunions have ended with the 60th. Noting the increasing longevity of doctors, the group voted unanimously to explore having another in three years. If this endeavor fails, the 60th will be our last! *Ave atque vale!*

Seebert J. Goldowsky '32



55TH

THE REUNION BEGAN ON A COLD AND damp Friday after Alumni Day exercises. We listened to the very entertaining discussions chaired by Dan Federman '53, with a faculty member and a student opening on several issues, followed by very pertinent comments from the floor about empathy and other things not easy to define. The atmosphere inside the tent was relaxed and friendly; Dan's skill as moderator is superb.

There followed the photograph, during which everyone managed to penetrate through the effects of 55 years of life and see his old classmates emerge. It seemed to take a remarkably short time. Recognition was complete about as soon as the pose was over.

This laid the groundwork for a very pleasant evening at the Country Club in Brookline, at which the damp light rain seemed to enclose us and make things more intimate. After a good dinner, Russ Elkington, our editor and perennial literary scholar, gave us an account of four medical men who attained fame in other fields, such as by climbing Mount Everest!

On Saturday morning the rain was less but still in evidence. We met at 9:30 for a minibus tour of Boston's architectural development. There were three accomplished lecturers who took turns describing the history and the importance of many buildings, streets and monuments, surprising us with their entertaining and very detailed accounts. This tour is highly recommended by all of us. There followed a lunch at the museum restaurant, and then a gallery tour by Mrs. Calderwood, focusing on American painters beginning with Copley and ending with Homer. We then shook hands all around in the museum lobby and expressed thoughts of 1997 as not being far away!

Jack Nunemaker announced at dinner that 14 years as class agent was enough, operating as he does from Los Cruces, New Mexico. But Bob Brownlee agreed to undertake this daunting task. Our class has 80 living, and of these, 19 managed to appear at reunion in rosy good health!

In attendance were Acheson, Bachhuber, Brown, Brownlee, Elkinton, Elliott, Emerson, England, Goldstein, Grandfield, Gusberg, Hearne, Heyl, Howland, Katzin, Lesnick, Liljestrand, Mindlin, and Nunemaker.

A.C. England '37

50TH

The Class of 1942 held its 50th reunion with what we all considered a superb turnout—approximately 100 classmates and wives. I say approximately because not every member who made an appearance attended all ceremonies and frivolities, so this figure represents an average and reasonably accurate figure for attendance.

Most of the class stayed at the Colonnade Hotel on Huntington Avenue—convenient to the medical school and with easy access to downtown occasions as well as shops, restaurants, etc.

The opening blast took place on Thursday at our home in Dedham, where a total of 98 congregated for cocktails and a sit-down dinner. The seasonal weather gods cooperated spectacularly with a warm, clear night and our azaleas, rhododendrons and assorted flowering shrubs timed their blooming perfectly. No bugs appeared! Whether this was fortunate or due to a recently installed "bat house" is immaterial. All those attending looked healthy and were certainly cheerful and exhilarated. It was an auspicious beginning!

Alumni Day followed the usual format, which will be described elsewhere, but it provided the atmosphere at the luncheon for further warm and cheerful exchanges and renewals.

On the night of Friday, June 8th, we gathered again at the Tavern Club, where items of Boston and Tavern history were recounted in the course of an excellent dinner and wines, followed by verbal anecdotes and reminiscences. The evening was topped off with a slide show by Andy Roddenbery of scenes from our 25th reunion.

After a brief respite for leisurely breakfast, buses left from the Colonnade Hotel for a guided walk through the Peabody Museum in Salem, which emphasized the glory days of the clipper ships and the Orient trade. This was followed by an excellent lunch in the museum. The buses followed a route that included Chestnut Street, where retired sea captains built their magnificent Federalist homes, designed by the brilliant "architect," Samuel McIntyre, a carpenter's assistant by trade. The restored area around Salem Harbor, Derby Wharf and the old Custom House (where Nathaniel Hawthorne clerked) provided a living background for the historical memorabilia at the Peabody Museum. As one who grew up in Salem on Chestnut Street and spent many cheerful summer days on Marblehead Neck, it was a particularly nostalgic occasion.

After the grim, gray skies of Alumni Day and Saturday morning, the sun broke out and the town of Marblehead and the "Neck" with its views of the ocean and of distant Boston, were spectacular.

An evening at the Pops provided a relaxed but stimulating finale to a memorable and nostalgic point in our lives. Sadness for our departed classmates and for those too ill to attend was a reality, but did not cast an inordinate pall over the time spent together. A number of classmates called or wrote with regret that one thing or another precluded their appearance. We reassured them that "God wot and God willing" we would all be back for the 55th and another bout of "Auld Lang Syne."

Oley Paul, who was deeply involved in the planning and organization of the occasion, together with Mel Osborne and Charlie Round, join me in thanking all of you for your exuberant and enthusiastic participation.

William V. McDermott '42

45TH

DAY ONE, THURSDAY. CLASS GATHERS at Tavern Club in evening. President Sandifer calls for a semblance of order. Series of reunion high points initiated. Recognition of presence of invited guests and spouses of departed classmates: Ricky Austin (Mrs. Drake), Phyllis Billings (Mrs. Edward), Mary Carson (Mrs. Paul), Mary Lee Ingbar (Mrs. Sidney). Introduction of Reverend Wade Hook, once of the Vanderbilt Hall U.S. Army. Preview of the Alumni Association presidential election, resulting in a predictable draw. Many speeches. Much conviviality.

Day two, Friday. Program at Quadrangle. Expected clouds begin to gather. Followed shortly by cooling(!) east wind. Election results announced. Stoeckle congratulated—also Swartz. Clouds lead convoy to York Harbor. Cocktail hour and dinner damage decibel scale at Stage Neck Inn.

Day three, Saturday. Rain drives all to indoor tennis courts, indoor shopping malls. Maine/New Hampshire economy reported to be turned around. Late afternoon running of the Belmont via satellite. Large bets placed with winnings and Promoter Sandifer's share committed to the establishment of 50th reunion class gift. Pre-prandial quiz by Sandifer. All pass. Final hands-on quiz at dinner. All non-New Englanders prove continued proficiency at lobster dissection.

Day four, Sunday. Glimpses of sun. Early planning for an in-between reunion (the 47.5th), likely somewhere to the west of Boston. Sites mentioned included California, Colorado, Cleveland, Worcester. Stage Neck nominated for 50th reunion weekend.

Pre-final note: Reunion committee to reconvene in fall for post reunion critique. Your input sought. Suggest changes. How about an in-betweener? Where? What season?

Final note: What made the reunion great? You did—by coming.

John A. Duggan '47

40TH

ABOUT 20 OF US CONVENED FOR OUR 40th, which, for the first time since our 15th, we spent wholly in the Boston area. Classmates like Yang Wang and Howard Rasmussen (and there probably were others) came back for the very first time—it was great to see them.

We all felt especially proud of '52, since George Bascom and Rial Cummings had written articles for the Spring *Alumni Bulletin* (George was guest editor, since the *Bulletin* was devoted to the practicing physician.) In addition, George also spoke feelingly about clinical practice—as he is so capable of doing—at Friday's Alumni Day event. Only to stress him further, his wife, Jane, who couldn't accompany him on this trip, fell and broke her hip at home in Kansas, cutting George's reunion activities to one night only.

The club of Odd Volumes hosted us the first night, thanks in total to John and Sylvia Constable. The address on Beacon Hill and all the expected charm of such a spot was fine tuned considerably by John and Sylvia. Friday in the rain in a tent at the Cochrans', we again enjoyed ourselves,

35TH

"NEW ENGLAND WEATHER BUILDS character!" might have been the rallying cry for our 35th reunion. (To which the class might have tartly responded: "We have more than enough character already!")

A few early arrivals enjoyed the sunlit luncheon in the atrium of the Medical Educational Center on Thursday. The weekend officially started with dinner at the Union Club that evening. Most classmates were recognizable by voice if not visage. Hairlines were higher and waistlines longer, but the personalities remained seemingly intact—seasoned, philosophical and upbeat. Speeches were mercifully brief, but included a tribute to Al Crum: his efforts as class agent have catapulted 1957 to the top four of all classes in percent of alumni contributing to annual giving. We were first in 1991. A surprise guest, robotic Dr. MAC (aka Harry Senger) gave us a glimpse of medicine in the 21st century. He is expected to return in 10 years to receive accolades for his skills at prophecy.

After shivering through Friday's program on the Quadrangle, 36 of the class and their spouses splashed through the downpour to Weekapaug Inn, on the far-flung Rhode Island coast. Conviviality bested the gales, and prevailed at cocktails and dinner. We had the inn to ourselves, it being pre-season. Saturday began and ended with fog, which dampened no one's spirit: beach-walking, tennis and sightseeing/shopping filled up the day, along with just schmoozing. The atmosphere was low-key and comfortable. As one wit has observed: "Middle-age is when you don't have to have fun to enjoy yourself." The indoor clambake was as lively as any held under the stars.

Sunday morning brunch wrapped up the weekend, ushering in (predictably!) the first sunlight in 48 hours. As couples set forth one by one, the sentiment appeared strong that a "get-away" reunion weekend was still the best idea: *respondez-vous?*

Peter Yurchak '57

and finally Saturday evening at the Harvard Club. Saturday, a smaller number of us toured "the new Boston" for its new parks and new architecture. Included was a fine tour and lunch at the Museum of Fine Arts.

Staying in different hotels made it more difficult for us to chat informally all day long among ourselves, but in compensation we didn't have to spend time travelling to a mountain or seaside resort either. As always, we missed all of you rascals who didn't come! We seem to have turned into quite a remarkable class (was it predictable?), but all your presences would prove and improve it.

Will Cochran, John Constable and Robert Lincoln '52

Doris Bennett (left) talks with a friend.

30TH

THE 30TH REUNION FOR THE CLASS of 1962 found 46 members of the class and friends coming back to one or more of the events during alumni week. This, in fact, compares quite favorably to the 55 who came to the reunion 5 years ago. Our reunion began after the scientific symposia on Thursday with an informal cocktail party at Eileen Ouellette's home in Newton. Everybody had a fun time renewing acquaintances.

On Friday, Alumni Day, once again a hardy group of people attended for the class photograph. The evening events included a reception at the Harvard Club, attended by 54 people, and then 40 went off to the Boston Pops.

Saturday started out quietly when a small group of us attended a tour of the Sackler Museum, the newest at Harvard University. This was followed by luncheon at the Taubman Center at the Kennedy School, which was quite gracious and enjoyed by all. On Saturday evening 60 members and guests attended a dinner dance at the Long Wharf Marriott Hotel, where entertainment, instead of being provided by Bill Donahue, was provided by music of the '50s and '60s. This was a fun time for all and included a number of people who had not been there for previous events.

Finally, a very hardy and small group met at the Boston Harbor Hotel on Sunday morning for brunch.

Once again, I hope that all who attended had a good time and we were disappointed that some members of the class could not be with us. Our sympathies go out to the family of Arnold Goodsit, who unfortunately passed away this February. We hope

25TH

WHAT A WONDERFUL AND REJUVENATING reunion! A large turnout and spectacular program added to the warmth and excitement of rekindled relationships.

The opening cocktail party at the Donoff's was a chance to say hello to old friends. Thursday's Class Day symposia were organized by Phil Goldsmith and his respective symposia chairpersons. Topics were broadly addressed, from the role of women in medicine through quality care issues, reimbursement problems, the current environment for clinical scientists, and finally "on being a doc after 25 years." The presentations were wonderfully personal, charmingly anecdotal and authoritative—emphasizing the breadth and depth of career experience represented by the Class of 1967. The final presentation by John Wesley was a moving description of a lifelong commitment to our beloved profession and the unique rewards that we all receive, with particular emphasis on the patient/doctor relationship. In fact, it is fair to say that the doctor/patient relationship theme permeated the entire reunion, including both our Class Day symposia and the Alumni Day program.

those of you especially geographically close by will plan to attend our 35th reunion. We truly did miss several people who have attended all the reunions in the past and for one reason or another could not make it this time. We hope that these people as well as those who for one reason or another have not felt any desire to come back, will change their minds as cerebral atrophy progresses. For the reunion committee, I thank all those who attended.

Samuel H. Kim '62

20TH

OUR REUNION GOT OFF TO A ROCKY start on Thursday evening when Roger Glass showed up at 5:00 pm to find no one in sight except for a janitor who knew nothing about the reunion. A few members of the class straggled in to the MEC at the appointed time of 5:30 to find no one else except themselves in a large vacant hall. The chairman of the reunion committee bustled in at 5:40 to find many surprised faces wondering why they had paid $24, since there was nary a glass of water, no less an hors d'oeuvres in sight.

Nonetheless, the sight of old friends overcame the assembled classmates. At approximately ten minutes of six, waitpersons appeared with an array of vegetables. On reflection, it wasn't that bad once the waiters got up to speed. The award for distance travelled went to Bob Nishimura from Berkeley and, in second place, to Diane Kittredge from Oklahoma City.

Photo by Michael Maloney

Phil Goldsmith '67

The frustrations of practice in today's society were well articulated. Jim Kahn gave a swan song before he departs to the world of corporate medicine and Beach Conger entertained us with Vermont homespun wit.

A wonderful dinner at the St. Botolf's Club topped off Thursday. Alumni Day activities were again focused on the fundamental relationship between doctors and patients, and seemed to take off where our class discussions on Thursday finished. Dan Federman '53 moderated a symposium that was an inspiration for all of us. Tom Gutheil '67 shared with us his wealth of experience on the more formal aspects of doctor/patient relationships and some of the medical-legal implications. Tom's reassurance that the fundamentals of good medical practice are the best defense was very reassuring.

On Saturday the morning clouds parted for some afternoon sunshine and a clambake at the Shulmans's home on Narragansett Bay in Rhode Island. There was consensus that the experience of this reunion was beyond all of our expectations. The issues were real, touched every one of us, and focused on our fundamental roles as doctors. Much of the cynicism of the '60s has passed with time, and it is clear that there is a deep reservoir of optimism and enthusiasm in our class.

The class proudly presented to the school a class gift in excess of $200,000! This is a record far exceeding previous gifts, and reflects the special effort of a five-year campaign. It is a small way for the Class of 1967 to say thank you to its beloved alma mater.

We all left with a commitment to stay in touch. There was enthusiasm for yearly get-togethers in those areas of the country where there are concentrations of classmates, as well as the possibility of an informal newsletter. In short, it was a great time and we are all looking forward to our next reunion.

Richard S. Shulman '67

Rich Harmel and spouse pulled in third from Tampa.

Only 10 members of the class showed up for lunch and a photograph on Alumni Day. Getting the class together was no different than 20 years ago. We had to take two sets of photographs to accommodate the stragglers and those intent on business other than having their photograph taken. Dan Smith was so distracted by his gourmet taco that he missed the first 10 calls for the photo. Perhaps he was trapped in flights of reverie recalling his glory days as an ob resident at LA County Hospital. Classmates lingered until the tents were pulled down, at which time we disbanded.

Following lunch, we had a nostalgic romp through Vanderbilt Hall with Diane Kittredge, Dan Smith and others. Some of us found our old rooms virtually intact and others found that they had gone the way of the original squash courts. We are impressed by the lovely athletic facilities, which include six new squash courts as well as weight equipment and stationary exercise equipment. The central tennis court remains in good, though slightly worn condition and is now surrounded by 15-foot pine trees, which were mere shrubs when we were all scut puppies.

The Class of '72 reconvened on Friday evening at the Bay Tower Club in downtown Boston. The spectacular view from the 33rd floor was lost on all of us, since we were enshrouded in a deep, dense Boston fog. The question is, did any of us ever emerge from the fog in the first place? Everyone was delighted with the new arrivals to the reunion, including Andy Diehl, Allan Goroll and John Whyman. The stalwarts of the reunion committee were there in force, namely Doctors Bajart (Dr. and Diz), Chin, Gallico,

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15TH

A SMALL BUT SPIRITED GROUP OF about 30 classmates come to our 15th reunion. Our class had responded enthusiastically to a wide-ranging reunion questionnaire, published in the reunion booklet. Findings included such facts as that on a scale from 1 to 5, men in the class averaged 4.49 in their rating of "happiness in my personal life," compared to 4.55 for women; while men averaged 4.32 in rating "happiness in my professional life," compared to 3.84 for women. Most of us would become doctors again (average 4.09, again on a 1 to 5 scale) and would have chosen the same specialty (average 4.04). While we don't especially "cherish our years at HMS" (average 3.09), we do feel that the "Harvard label" has been good for us (average 4.21).

Only a dozen or so classmates braved the cold and rain on Alumni Day, but some, such as Michelle Copeland and Jerry Spunberg, brought their families to show their kids "where it all began."

Friday evening witnessed a sumptuous gathering at Dori Zaleznik's house in Newton for a chance to renew old friendships. Spirited conversations ranged from the nature of the family medicine training program at HMS then and now to the political campaigns, or whether the reunion questionaire should have asked "Who does the laundry in your household?" rather than "What model of computer do you own?" Of course, there was the usual catching up on what's been happening in people's lives since the last time many of us saw each other five years ago. Honors for traveling the farthest to rejoin us for the weekend go to Judith Brill and her family.

Saturday afternoon found us at Bob Taylor's lake-front house in Worcester. The weather widely ranged from thundershowers to sunshine, but spirits were never dampened. We enjoyed barbeque, music, boating and fishing, as well as the old-fashioned joys of running after an ice cream truck and sighting the most spectacular rainbow most of us had ever seen.

We hope to keep in touch and look forward to our 20th in 1997.

Gil Brodsky '77

Cabot, Schemmer and Drazen. David Goldman, Roger Glass and Steve Varga-Golovcsenko were a trio of double dippers, dividing their time between their Harvard 25th college reunion and their HMS 20th. The lure of the swing band attracted no one, since intense conversation seemed more the order of the evening than cutting a rug. We were all happy to have Margo Green, Larry Green's widow, join us for dinner. Their babies are now college graduates. The end of the dinner was greatly similar to the days of yore after dinner at Vanderbilt Hall.

Saturday boded ill with dull fog and drenching rain as dawn broke over Boston. By some meteorologic miracle, the rain stopped and the sun's heat could be felt through the clouds (global warming) as the clambake time drew nigh.

Ann M. Bajart '72

Photo by Barbara Sinder

Al Sommer '67

10TH

OUT 10TH REUNION WAS A GREAT success. Over 25 percent of our class returned, accompanied by family and friends. Bob Peterson receives the award for farthest distance traveled: he arrived at our class dinner after having flown from Hawaii. Orlando Kirton even interrupted his surgical residency to attend—obviously he didn't need much of an excuse, but we were glad to see him and his lovely wife, as well as a thousand pictures of his new baby.

Other attendees included the Goffneys, Taubers, Birnbaums, Mike Glafkides, Diana Mrvos, Ann Miller, "Ben" and Mindy Levine, the Narretts, Jim O'Connell, Pete and Marjan DiBattiste, the Paganellis, Urmeys, Verhaves, Mendelsohns, Hellers, Bob Husson (newly arrived in Boston) and the list goes on and on. Those of you who were unable to attend were sorely missed and certainly talked about. Hopefully in five years we can double our attendance.

The weather didn't cooperate fully, but it didn't seem to matter. The cocktail party at the Pursley's home was wonderful with great food and lots of laughs. It's funny how little 10 years seems to matter. Seventy-plus people attended dinner at my house, which featured excellent fajitas and ribs from the Iguana Cantina. The special anti-cat tent allowed Bill Urmey to join in the festivities. Martha the cat, however, did get her revenge. Hats off for Tammy for bringing their six-day-old baby. The next day people were slow arriving at the picnic, but certainly had reasonable excuses. By the end of the afternoon, over 50 people were in attendance. I think I'll never forget the site of all those little children running through that huge puddle outside the hockey rink. The reunion was capped off by a lovely Charles River dinner cruise, with a surprise tour of Boston Harbor.

On behalf of the Class of 1982, I would again like to thank Dewayne and Maureen Pursley, Pete and Marian DiBattiste, Jim O'Connell and Robin Griffey (especially for helping with Martha's antics) and Nora Nercessian of the alumni office. Special thanks go to my wife, Patty, who was the driving force behind the reunion planning. Without her it would not have been anywhere near as enjoyble.

Let's do it again in 1997. Just one note of caution: if you don't want any nasty editor's comments in the reunion booklet, then next time let us know what you've been doing for the last five years.

Stephen T. Swerdlik '82

5TH

WE HAD A WONDERFUL RESPONSE TO our fifth-year reunion report. The unique and diverse interests of the Class of '87 were clear. There were a few still in medical school and rumor had it Tom Schuetz was somewhere between gel and a vortex the night of the reunion. At the other end of the spectrum, Brandon Fradd stopped in on his way from San Francisco to Wall Street to give us highlights on his career as a financial analyst for Montgomery Securities. (Yes, he still wears bow ties and could probably pay off all of our combined school loans in full!) Most of us reported that we're extremely happy with our careers in medicine. Those who were not, felt they had to sacrifice too much of their freedom and personal lives.

The Class of '87 activities began with a cocktail reception at Vanderbilt Hall. Rob Glassman made a guest appearance and all those present agreed, "Rob, you're looking massive!" On Saturday about 50 of us joined together to enjoy old stories, wonderful views and great food at the Bay Tower Room. Wedding bells were ringing for soon-to-be-married Rick Born and Anne Watson, and John Winkelman and Janet Wozniak recently wed. Baby pictures were flying, but special congratulations to Tony and Nella Massaro, who called the Bay Tower Room from the BWH to report the birth of their new daughter, Marisa. Elissa and George Gittes are expecting, and this list of '87 kids was exciting.

The evening ended with a few stragglers having a cocktail and looking out at Boston Harbor. Except for the view, the aura was very close to that of the old "terminal bar." Hope to see everyone at the 10th!

Diane Fingold '87

Donald Gordon '22 and Ting David Lee '57

Harvard Medical Alumni Association
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